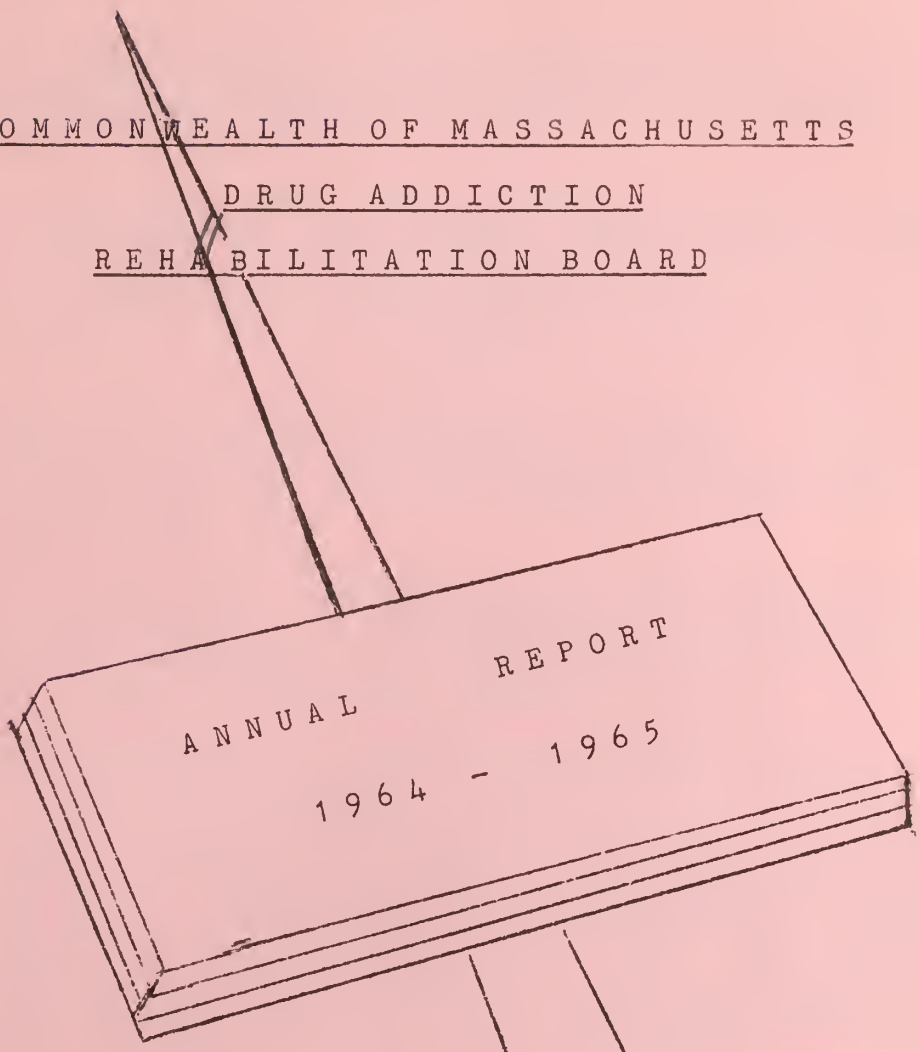
COMMONWEALTH OF MASSACHUSETTS

DRUG ADDICTION

REHABILITATION BOARD



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Administrator

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On January 17, 1964 "An Act Providing A Program For The Treatment And Rehabilitation Of Drug Addicts, " Chapter 763, Acts of 1963, became law. This act authorized the setting up of a "Drug Addiction Rehabilitation Board" within the Department of Public Health, but in no manner subject to its control, consisting of the Commissioners of Public Health, Mental Health and Correction. The Commissioner of Public Health is to serve as Chairman of the Board.

This unique administrative structure offers representation from the three departments most intimately concerned with the panoramic problem of drug addiction. Concurrently, it also serves to channel the resources of the three departments into one concerted and coordinated effort.

Chapter 763 further states: "The Board shall establish a program for the treatment and rehabilitation of drug addicts, shall coordinate the services and activities of other agencies of the Commonwealth and of its political subdivisions in the treatment and rehabilitation of drug addicts, and shall cooperate with agencies of the federal government in developing and coordinating such programs."

The Board shall appoint an administrator of the drug addiction program who shall also serve as the executive secretary of the Board. The administrator shall administer the the total program and also plan, stimulate, support and develop educational and research programs. Lawrence D. Gaughan is Administrator of the Drug Addiction Rehabilitation Board.

During the fiscal year 1964-1965, the Board held seven meetings — one meeting at Boston State Hospital, two meetings at Room 546, State House, and the remainder at 8 Beacon Street, Boston. An administrative office was established on May 1, 1964, at 8 Beacon Street, Boston, Massachusetts 02108.

The major features of the legislation are the following:

I. It recognizes drug addiction as primarily a disease, as does the United States Supreme Court. In terms of the law it defines a drug addict as one who is so dependent upon narcotic drugs that he loses his power of self-control and is thereby a danger to himself and to the public. Implementation of the treatment and rehabilitation program of the Drug Addiction Rehabilitation Board requires an interdisciplinary approach. Physicians (including psychiatrists), social workers, public health educators, sociologists, psychiatrists, lawyers, teachers, etc., all have a role to play.

II. It authorizes the Board to systematically build a diversified treatment and rehabilitation program for drug addicts in Massachusetts.

Within the treatment program, each center or facility will direct its focus to a specific group of addicts and specialize in developing methods of treatment most appropriate to them. Each facility should supplement the functions of the other, all working within a total integrated treatment effort.

Inpatient and outpatient facilities located throughout the state will serve to implement this program. They may include treatment centers, out-patient clinics, a halfway house, a sheltered workshop, statistical data center, a laboratory, forestry camp, day care center, etc.

The first Drug Addiction Treatment Center and Out-patient Clinic was officially opened November 9, 1964 at the Boston State Hospital, Mattapan, Mass. Dr. David Myerson is Medical Director of the unit.

The unit had been open, however, since July 1, 1964 extending service to addicts. It did not have a complete staff for a formal opening until November 9, 1964

Boston State Hospital was selected for the first site of a drug addiction treatment unit because it met all of the requirements recommended by the Presidents Advisory Commission on Narcotic and Drug Abuse. They are the following:

I. Treatment units for drug addicts must be located in urban areas where the majority of addicts reside. If the goal of a treatment unit is to help the addict make his way in the community then the services that support him should be readily available in his neighborhood. Boston State Hospital is located within the confines of the City of Boston and near public transportation.

II. A treatment unit for drug addicts should be part of a total integrated program offered by a general hospital or mental hospital. Boston State Hospital offers medical services, laboratory facilities, intra-hospital vocational opportunities, twenty-four hour chaplain service for the three major faiths, and is also equipped to handle emergency cases. Boston State Hospital is also an experimentally-oriented hospital providing students and researchers with a stimulating and educational environment.

The Board is deeply indebted to Dr. Milton Greenblatt, Superintendent, for the enthusiasm and encouragement he has rendered to the drug addiction treatment program.

III. In order to guarantee individualized attention for patients, treatment units should be kept small, preferably no more than 25 beds. The treatment unit at Boston State Hospital currently has 12 beds with additional room for enlargement to 17 beds.

It provides the Commonwealth with a flexible treatment and rehabilitation program for drug addiction. Addicts may be admitted to the Drug Addiction Rehabilitation Program under one of six different procedures:

A. Civil Commitment Procedures - Civil commitment is a legal mechanism utilized in lieu of a criminal commitment to ensure control over addicts during rehabilitation; first in a treatment center, later perhaps in a half-way house, still later in the community under supervision of an aftercare worker.

1. (Section 4) - Petition for commitment of a drug addict to the Drug Addiction Rehabilitation Board may be made by the Medical Director.
2. (Section 6) - Criminal proceedings against a drug addict are set aside by the district court when commitment of a drug addict to the Drug Addiction Rehabilitation Board seems beneficial.

B. Voluntary Treatment (Section 2) - The Drug Addiction Rehabilitation Board may establish or provide for the establishment of facilities for outpatient treatment, including voluntary treatment of drug addicts at a rehabilitation center or elsewhere.

C. Outpatient Treatment (Section 2) - See above.

D. Parolees (Section 9) - The facilities of the Drug Addiction Rehabilitation Board are available to persons on parole.

E. Probationers (Section 8) - Commitment to the Drug Addiction Rehabilitation Board may be made a condition of probation for a drug addict.

F. Emergency Commitment (Section 3) - The treatment center will accept a drug addict for a fifteen-day observation period on a voluntary or court commitment to determine the need for further hospitalization or release to the community.

IV. Court commitments are for a two-year period which may, at the discretion of the court and the medical director of a center, be extended for one more year. It is estimated that the length of

hospitalization for a patient at the treatment center will last approximately ten to twelve weeks. The initial two weeks will be the withdrawal period. The second two weeks consists of occupational therapy. During the fifth and sixth weeks the patient is allowed to leave the ward and assume some vocational responsibilities within the hospital structure - i.e., working in the mailroom, the laboratory, cafeteria, etc. The remaining six weeks will be occupied with day care, night care, and the preparation of the patient for after-care supervision in the community. Individual needs of a specific case, however, will primarily dictate treatment procedure. Based on the judgment of the medical director of the center, a patient may be placed on day care, night care, or outpatient-follow-up treatment and supervision.

V. The Act provides for a required follow-up program of court-committed patients in the community. Specially trained personnel attached to the program will conduct the follow up. Even though a patient is the recipient of the best available treatment within the Drug Addiction Rehabilitation Center, his subsequent course will depend to a significant degree on the efficacy of the program's after-care services.

Effective aftercare services may entail employment help or vocational training, working closely with the family of the addict as well as with the addict, and utilizing all community resources that can offer the addict support.

Relapse to addiction requires retreatment and cannot be taken as an indication of failure, but should be accepted as in any other relapsing disorder. Evidence indicates that with the passage of time and firm supportive assistance from an aftercare worker, patients tend to become more responsive to treatment and can "mature out" of addiction.

INFORMATION AND EDUCATION

The Drug Addiction Rehabilitation Board has developed an extensive educational program on drug abuse. This was necessitated by the gross misinformation and misconception prevalent in the community today concerning the abuse of narcotics and "dangerous drugs." Only through such an educational campaign can the Board hope to correct distorted attitudes and fallacies about the drug problem.

The focus of the educational prevention program has been to make the public, especially the teenage population, conscious of the full range of harmful effects, physical and psychological, that narcotic and dangerous drugs can produce.

One school of thought opposes educating teenagers on the dangers of drug abuse since it is felt that it would only lead this age group to experimentation and possible addiction. The Drug Addiction Rehabilitation Board, however, feels that the teenager should be educated to the dangers of drug abuse by their parents, the schools, churches, and specialized community organizations-i.e., Drug Addiction Rehabilitation Board - rather than by a street addict or the underworld.

Information and education, rather than repression, is the best weapon to fight the spread of drug addiction amongst all age groups in Massachusetts.

The comprehensive approach of the Drug Addiction Rehabilitation Board's prevention program has been primarily conditioned to reach three major bodies:

1. The General Public - Articles and news releases have been submitted to newspapers, periodicals, and magazines; staff personnel have participated in television productions and radio programs in Boston and Worcester; speaking engagements to civic groups (P.T.A., churches, etc.) have also been made.
2. Professional Bodies - Courses of instruction in drug addiction have been conducted by the administrator and directors at medical and nursing schools, and at Bridgewater State Teachers College. The Drug Addiction Rehabilitation Board has urged professional graduate schools to strengthen their courses, including subject matter on the legitimate use of narcotics and drugs, and provide more knowledge of the dangers involved in drug abuse.
3. Teenage Population - Educational and informational material has been distributed upon request to over 500 high school and college students writing term papers or thesis. The interest about the dangers of drug addiction amongst young adults is intense and searching. Due to shortage of personnel, the educational and informational program has not been fully implemented. Plans to wage a more aggressive campaign against the spread of drug addiction are available and are awaiting trained personnel to execute them.

BASIC TREATMENT APPROACHES

Drug addiction is a problem both in terms of the ravages it produces in those so afflicted and in the difficulties involved in the treatment of this type of deviance. The physiological dependence that results from drug use complicates the severe psychological and social problems with which most addicts are burdened. Different methods have been used, or advocated, in rehabilitation programs both in this country and abroad and though none have proven completely effective for all types of addicts, there now seems to have emerged several clearly definable orientations to the treatment of addiction. Each of these orientations has specific practical ramifications for treatment procedures and each has advantages and disadvantages.

Aside from the negative view that addiction is a moral weakness and that the best disposition for the addict is prison, there appear to be four approaches to rehabilitation which are now fairly well crystalized. It should be noted that the four approaches described below are not mutually exclusive and that there is considerable overlap in some cases.

I. The first two approaches may be subsumed under the rubric of addiction as a medical problem. If addiction is viewed strictly as a medical problem, it is often seen within the framework of the neurophysiological functioning of the human organism. In this view, the emphasis is upon addiction as a disease and exploration of the influence of drugs on the physical and psychic functioning of the individual, and upon means of affecting and controlling these effects. The means used or explored, may range from surgery - e.g., the deactivation of areas of the brain through study of the physiochemistry involved to the use of other drugs to counter psychotoxic effects. An example of the latter is the experimental program now underway at the Rockefeller Institute and Manhattan Hospital in New York where addicts are maintained on massive doses of methadone, a synthetic drug which appears to have the effect of making it possible for them to operate normally and eliminates the need for the drugs to which they were formerly addicted. The precise reasons for the preliminary results that the physicians at Rockefeller Institute have obtained will be known only after further careful research, but this is a good example

of one approach to the problem.

II. Another perspective on addiction which properly falls into the medical framework is the psychiatric approach. The principal assumption of the psychiatric approach is the belief that addiction is the result of a psychological disability. Organic and physiological factors may be taken into account by this approach as well as the social context in which the patient lives, but the principal effort is directed toward the internal psychodynamics of the patient. In this view it is held that the psychotherapist, by helping the patient to develop insight into his own pathology, will enable the addict to rid himself of the need for taking drugs in order to escape from anxiety and inner turmoil. Although the goal of this orientation is, like other treatment approaches, to enable the addict to stop using drugs and function in a normal manner, less stress is placed upon the addict's behavior during treatment and more upon his developing insight into his problems. It is also felt that the long, slow, and careful development of the relationship between the patient and the therapist and the exploration of the patient's psychic difficulties are extremely valuable aids in learning more about the causes of addiction and the measures needed to both prevent it and cure it.

III. Still another approach to the treatment of addiction is represented by what might be termed the non-professional, self-help, total abstinence attack on the problem. While such widely divergent groups as Synanon, Teen Challenge, and Drug Addicts Anonymous disagree strongly on given points, all have certain elements in common which are different from the other perspectives on the problem considered here.

All of these groups emphasize the need for the individual to make a radical decision to change his drug-using behavior abruptly, and to abstain totally from drugs and alcohol. This is always with group support and usually the group is made up in part or wholly of others who have had the same problem. In this view, behavior change and commitment to a different way of life (in some cases with a religious rationale) rather than insight into psychological problems are the foci. Objective evidence of the range of addicts to who this kind of program could prove useful is not presently available. Programs of this type have, however, achieved some well-publicized success with a certain number of cases.

IV. A fourth perspective on the problems of treatment and rehabilitation of the drug addict takes into account both the needs of the addict and the community. This might be termed the functional-authoritative approach. This approach makes use of professional staff (medical, psychiatric, social work, and psychological) and whatever other resources are necessary; for example, vocational training. The emphasis here is upon assuring the functioning of the patient wherever possible even though his psychological disabilities may not be completely resolved. The authoritative aspect means that, once embarked upon a program of treatment, the patient is helped by the application of external controls of one sort or another - non-punitive controls - to sustain his motivation and participation in the program. Each case is, of course, handled on an individual basis in relation to such questions as the need for insight therapy or for more directive and supportive counseling. This kind of program is correlated with civil commitment laws, and the States of New York, California, and Pennsylvania all have such programs. There is indication that for a large portion of the addict population such pro-

grams are very helpful. Careful research is being carried out to evaluate such programs.

The program of the Drug Addiction Rehabilitation Board closely resembles the functional-authoritative model. In the first place, the activities of the Board go on under an enabling law the clear intent of which is the use of external control in the form of civil commitment. The Board program focuses upon the attempt to help the addict function in the community and deal with "real world" problems of staying off drugs, holding a job, and dealing as adequately as possible with the stresses of normal living.

To accomplish this, it is necessary to use differing emphasis in dealing with different patients. For example, some will profit by a degree of psychotherapy while others prove to be so highly disturbed that when withdrawn from drugs they exhibit psychotic symptoms and are not appropriate candidates for treatment within the program. Others have a degree of psychological disability that is best handled by supportive and directive help. This help is characterized by measures which aid the addict in his struggle to function in the community, and focuses upon whatever strengths he may have - i.e., job skills, rather than any exploration of the psychodynamic problems he is subject to. In this kind of program, the follow-up activities in the community become extremely important.

THE PLACE OF RESEARCH IN THE PROGRAM

Chapter 763, Acts of 1963, placed heavy emphasis on the research role of the Drug Addiction Rehabilitation Board authorizing specialized "research programs on the causes of drug addiction."

The initial role of the research program is to provide the Board with facts and statistics needed as an aid to administrative planning in the development of the program. Research activity deals with several areas and is two-fold. Generically, there are long range goals of basic research into the social, psychological and medical aspects of drug addiction and abuse, and the evaluation over time of the effects of different treatment modalities within the program. Equally important and urgent are the immediate shorter-range goals of ongoing data-gathering and constant reevaluation of the treatment and rehabilitation effort. Dr. Victor A. Gelineau is Director of Research for the Drug Addiction Rehabilitation Board.

THE MAJOR AREAS OF RESEARCH

Although all of the research carried out by the Board is closely interconnected, the decision was made to divide the research program into three distinct areas of effort. One of these is the study of the person who manifests a drug problem. In this study of the individual patient there are two interlocking sets of variables-psychological and sociological. Any understanding of addiction requires a careful evaluation of the psychological characteristics and developmental history of the addict as an individual. Data is needed which can shed light upon the personality structure of the patient and how it evolved. Along with the dimension of personality variables, the individual should simultaneously be studied from the standpoint of what can be called his sociological attributes include basic and important demographic facts such as age, sex, education, and race, as well as more complex social histories which may indicate the social contexts and interaction patterns in the individual's background.

A second major focus of the research includes an evaluation of the treatment process. This means, of course, an assessment of what effect the treatment program has upon the rehabilitation of individual patients. This kind of evaluation

is important for a number of reasons. First, in all of the programs throughout the country which are treating drug addicts, experience has shown that the rate of cure is not high and that this is a very difficult rehabilitation problem. It is, therefore, very important to identify by careful study any treatment process which has a rehabilitative effect. Additionally, it is important to develop criteria of various levels of success. Addiction is not a problem for which one can expect dramatic cure. The rehabilitation of the addict is a slow process that may be marked by the well-known tendency of the addict to relapse into using drugs after extensive and repeated treatment. The gross index of complete abstinence from drugs, as a measure of rehabilitation is unrealistic. Complete abstinence is the goal of treatment, but other measures are needed to indicate progress along the way to this goal. Finally, given the fact that addiction is a problem that involves the personality and interpersonal relations of the addict and often makes him a very difficult management problem in the treatment setting, it is important to examine the treatment program as a small social system. Staff-patient interaction, the reactions of patients to various aspects of the rehabilitation program, and the structure of treatment facilities are important items of data.

The third major focus of the research consists of studies which examine the community setting of the problem. These studies include epidemiological surveys which attempt to find out the extent of the problem, its geographical distribution in the Commonwealth, the characteristics of drug users and addicts, and similar data. Other studies will attempt to find the effects of various environmental conditions upon treated and released patients. Facts and statistics of this nature can then be used by the Board in their planning for the most effective use and distribution of rehabilitation resources in the Commonwealth.

RESEARCH AND EVALUATIVE TECHNIQUES

Each of these major areas of research requires a different set of techniques. For the study of the individual patient, standard psychological tests and clinical evaluations are being used. The research program has also developed additional measures for the assessment of important psychological dimensions. Social histories are taken on each patient and carefully structured interviews designed to obtain significant psycho-social data are carried out. Additionally, a careful record using several different instruments is kept of the patient's behavior while in treatment.

The treatment program is evaluated by several different techniques. Its effect on patients is noted by checking drug-using behavior, by recording any psychological changes as revealed by psychological testing and clinical assessment, and by documenting behavorial changes in such areas as work performance, family adjustment, and so forth. Records of staff-patient interaction, measures of staff attitudes toward patients, and observational data on the overall operation of the ward are also systematically collected.

In the third area of research, the community setting, efforts have been concentrated upon learning more about the number of addicts and drug abusers in the state and the distribution of the problem. A difficulty here is the lack of systematic and centralized information on drug addiction and abuse. A pilot project has received extremely helpful cooperation from other state agencies which have made data in their possession available to the Drug Addiction Rehabilitation Board. These agencies include the Department of Correction, the Department of Public Safety and the Department of Probation. The pilot study has already gathered pertinent information on more than seven hundred individuals with drug problems who have come to the attention of public agencies. The success of the initial phases of the pilot study has prompted the design of an extensive epidemiological survey which will

cover all sources of information throughout the state, and develop a systematic central repository of information on the problem. The administrator and the director of research have held extensive discussions with officials of the United States Department of Health, Education and Welfare, Public Health Service, and the National Institute of Mental Health, concerning the study. These officials have expressed considerable interest in such a study which is in accord with Recommendation 6 of the President's Advisory Commission on Drug Addiction and Abuse, and have indicated that our design was the first in the country to outline a comprehensive plan for the systematic and centralized gathering of data on drug addiction and abuse. They suggested that this plan could serve as a national model. A proposal has been submitted requesting funds from the National Institute of Mental Health for the implementation of the study.

TENTATIVE CONCLUSIONS & SOME STATISTICS

Along with the collection of data to implement long-range research goals, ongoing research includes the gathering and analysis of facts and statistics of immediate interest. These include information on the number of patients treated, the disposition of cases, selected characteristics of the patient population, and aspects of the treatment process. The statistics that follow include the period from July 1, 1964 to June 30, 1965. However, it should be noted here that the treatment unit at Boston State Hospital was not opened on a full time basis as a twenty-four hour facility until November 9, 1964. Prior to that time (from July 1, 1964 to November 8, 1964), the unit did not have a full complement of personnel and operated on a limited basis with a skeleton staff. Consequently, information on patients and other aspects of the treatment program, while included in the present report, is not complete for that period.

Our statistics show that since the initiation of the program on July 1, 1964, 162 individuals formally contacted the treatment program for assistance. This figure includes only those individuals who identified themselves, stated that they had a drug problem, and made formal application for treatment and an appointment to be seen by the clinical staff. Many others made tentative contact with the program. Between 450 and 500 inquiries were received by the treatment unit and the administrative office. It is difficult to categorize these inquiries in statistical form since they were often calls from relatives, friends, attorneys or others close to people with drug problems, and were highly informal in many cases. Often, the questions about the availability of treatment might be termed over-casual as people attempted to probe and secure information about the program without exposing themselves to the stigma of drug addiction. It is impossible to determine just who these people were in terms of social characteristics since they were often hesitant to identify themselves in any manner. However, enough of them volunteered information that indicated the inquiries did not come from any one group and represented several social levels in the population.

Those who made formal application for treatment came from a number of sources. Some read of the program in the local news media--radio, television, etc., which have given excellent and understanding coverage to the Board's efforts and have shown an enlightened and progressive attitude toward the program. Others heard of it by word of mouth, sometimes from other patients, and came for treatment of their own accord. A certain proportion were brought or referred to the unit by friends or relatives who were concerned about their condition. Others were referred by doctors, hospitals, and, in some cases, by lawyers on the advice of doctors. Additionally, since the law under which the program operates provides for civil commitment of addicts as well as for making treatment in the program a condition of probation or parole, a number of people with drug problems were referred to the Drug Addiction Rehabilitation Board by the courts and probation and parole authorities.

These various sources have contributed unevenly to the total load of the treatment unit. Approximately one-third of the referrals came from the courts and probation sources while another third were self-referrals. About one-quarter were referred by medical sources and the remainder by families and friends. Obviously, the channels through which people came to the Board may vary over time, but the figures for this first year of operation reveal that the service is reaching more than one category of client. The number of court and probation referrals indicates that the Board is serving its function as intended under the commitment law in treating individuals whose problems include difficulties with the law.

Of the 162 persons who made appointments to be treated twenty-six, or about 15 per-cent did not keep their appointments. Many addicts or drug users are concerned about their condition and make attempts to seek treatment but are not strongly motivated to discontinue the use of drugs. It is inevitable that some will not keep appointments and will hesitate over a long period of time before actually beginning treatment. However, the addict's motivation may increase over time and once he is made aware of the existence of the program and goes so far as to contact it, there is a small but important increment. The very fact that there exists a program where help is available is an element in increasing motivation. This is particularly true when Board personnel are helpful to persons making inquiries or appointments and outline the program to them so that they will be aware of what it consists of and what they can expect from it. This means that the addict then has a known quantity to deal with and knows that trained people are available and willing to help him. This type of assistance which is provided the addict may be termed pre-treatment counseling and is an important function which becomes a factor in his ultimate decision to accept treatment.

Of the 139 patients who came to the hospital, some had long-term addiction and very low motivation for cure. Others had come to the hospital in the hopes that maintenance doses could be obtained. Still others hoped merely to reduce their tolerance for the drug so that they might obtain the same results with a smaller amount of the drug after hospitalization. In all of these difficult cases, three functions were carried out by the staff: (1) the fact that maintenance dosages could not be obtained was emphasized; (2) the nature of the program was carefully explained and again pre-treatment counseling was given as the first step toward developing motivation; and (3) an evaluation and diagnosis of the patient was made.

For six of the patients seen by the staff, referrals were made to other hospitals or clinics located closer to the patient's community where he might more easily get the help he needed. In all of these cases, consulation and communication between Board staff and other institutions was maintained.

Experience in other programs has shown that the rehabilitation of a drug addict or abuser is a long-term process often taking as much as three to five years. Also, it is not an uninterrupted process which progresses smoothly from initiation to cure. Patients will often leave treatment but will then return, and each time the treatment is taken up again there will be small increments of gain. This has been the case in the Commonwealth's program. In some cases, patients have left against medical advice but a strong enough relationship has been developed with the staff so that they have later returned and made greater progress toward rehabilitation.

Of the 139 patients who entered the treatment program at the Drug Addiction Rehabilitation Board treatment unit, a few were immediately accepted on an outpatient basis. Depending upon the nature of the individual case, a patient may be treated on an inpatient basis and then released and treated in the community in the after-care portion of the program, or he may be treated on an inpatient basis with-

out being hospitalized if the medical director judges this to be the most effective way of handling the case.

An additional complication to the treatment of addicts is the fact that they are often in difficulties with law enforcement authorities. Cooperation between Board staff and other agencies involved with addicts has been good. Some patients, however, violate laws during their treatment program and are incarcerated. This occurred with six patients; four of these six patients who were incarcerated maintained contact with the center and will return to treatment on completion of their sentences.

On an average day at the treatment center, approximately 47 patients are in active treatment -- 12 as inpatients "on the ward" -- 18 in the aftercare program, and 17 attending the outpatient clinic.

In addition, since the role of the family is significant in the problem of drug addiction, group therapy is being carried out with the families of ten patients and regular home visits are made by social service staff to eight other families. The experience of other programs both in New York and Philadelphia, for example, has shown that working with families is valuable and important. The Board program has achieved significantly higher attendance by family members at group meetings than other programs have and it is expected that this will bear fruit over a period of time.

Although the inpatient census is automatically restricted by the fact that the treatment ward is a small experimental unit with a limited number of available beds, the outpatient and aftercare load continues to increase and will become greater in the future.

THE DRUGS INVOLVED

The range of drugs which patients use and to which they are addicted is another indicator of the severity of the problem. For most patients, there is a so-called drug of choice which they use in preference to others. All patients will, of course, resort to other drugs when their drug of choice is not available. Also, it is quite common for addicts to use alcohol in excess when drugs are not available or are in short supply. Too, a number of addicts have had a problem with alcohol before becoming addicted to drugs.

For admission to the Drug Addiction Rehabilitation Board Program, the individual must be addicted to narcotic drugs as defined by the laws of the Commonwealth. All of the patients who were treated (139) have been addicted to one form or another of the narcotic drugs and a proportion of them-about 15 per-cent - were regular users of several drugs.

The various drugs used are:

I. Heroin -- The largest single category of addicts -- slightly over half -- are those who use heroin, which is probably the most severely addicting of the narcotics. Of those using heroin, approximately three-quarters were non-white. Fewer whites use it as the distribution of heroin is, in the Boston area at least an aspect of the non-white subculture. Heroin is not usually brought in directly through the port of Boston but comes from New York. The price of illegal heroin is far higher than it is in New York and the quality lower. It is difficult for anyone not familiar with, and not accepted in,

the non-white subculture to obtain heroin in Boston.

II. Legitimate and Medically Useful Narcotics--The next largest group - well over one-third - are addicted to what might be called the medical narcotics. These are preparations which are either derivatives of opium such as morphine or codeine or synthetics like dilaudid and methadone. Unlike heroin, these drugs are legitimately manufactured and distributed for medical use and are important therapeutic aids to the physician. Addicts obtain these drugs in a variety of ways; two of the most common being theft and forging of prescriptions.

III. Exempt Narcotics — The remaining group of addicts which is at present not as large as the previous two is the group of people who are addicted to what are termed the exempt narcotics. The exempt narcotics are drugs such as codeine, dilaudid and opium which are part of proprietary medicines (such as certain cough syrups) and of paregoric, which has long been a common household remedy. Although this group is not as large, it is on the increase, and is a particularly serious problem since it is made up primarily of young people who are having their first drug experience. These young people are apt to be unaware of the seriously addicting properties of the drugs contained in these preparations, which they sometimes ingest in almost unbelievable quantities to secure the euphoric and anxiety-relieving effects.

IV. The Harmful Drugs — A considerable number of patients have been addicted to the barbiturates as well as to narcotics. Another serious and growing problem is the addiction to and abuse of drugs other than the opiates and their synthetic derivatives, termed the harmful drugs. These drugs, particularly the barbiturates (which include commonly used sleeping pills such as phenobarbital, seconal and nembutal), the amphetamines (benzedrine and dexadrine), and other hypnotic and sedative drugs such as paraldehyde and doriden.

Barbiturate addiction is a greater danger than is commonly realized and withdrawal can be extremely severe, sometimes resulting in coma and death. Barbiturates and amphetamines are commonly used by addicts to supplement their narcotic intake when supplies are low. Additionally, an increasing number of people not addicted to narcotics are abusing barbiturates and amphetamines and, in many cases, becoming addicted to them.

V. The Hallucinogens — Another problem area in the field of drug abuse and dependence is the class of drugs called hallucinogenic, or psychotoxic. These drugs include the various derivatives of ergot and synthetic equivalents — e.g., lysergic acid and LSD, peyote or its active principal, mescaline and psilocybin. Although not addicting in the physiological sense, these drugs have a highly dangerous potential and there is evidence that their use is also on the increase, particularly among college groups. The number of patients treated at the unit who had experience with these drugs was not large, but they must be considered in any overall appraisal of present and future problems and programs. At present, the law does not provide for treatment of these patients unless they are also addicted to narcotics. Program efforts on this score have concentrated on educational and preventive aspects.

VI. Marijuana — Still another drug which is not addicting in the physiological sense but is cause for considerable concern among enforcement authorities, particularly since they feel it is on the increase, is cannabis or, as it is commonly known, marijuana. Since the patients at the treatment unit were all addicted to the more

potent drugs, the use of marijuana was not common among them. However, it appeared prominently in the drug histories of many and often was the first drug used and was followed by "graduation" to other drugs, including heroin.

In summary, then it would appear that within the Commonwealth there exists a wide range of drug problems, intensifying the necessity of immediate planning for the future.

DEMOGRAPHIC VARIABLES

Some of the basic demographic statistics gathered give some indication of the population the program is serving. There was considerable range in the age distribution of the people who came to the program for help — from 16 to 77 years. However, the mean age of all patients was 32.5 years while the median age was 31. There were slightly more than twice as many males as females in treatment and the mean age of the males was 31.4 and the median, 30. For the females, the figures were slightly higher — 34.5 and 33. The racial distribution was not equal; there were more whites than non-whites. The age level for the non-whites was somewhat higher. The mean age was 33.9 years and the median 33.5, while for the whites the figures were 31.1 and 26.5, indicating a larger number of young patients among the whites.

As more of this factual data is gathered over a longer period of time and compared to the results of other research, more useful conclusions can be drawn concerning the population that is being served. However, several points of interest appear in the material already available: first, the average age level of the patients indicates that the program is faced with difficult cases of individuals who have been addicted for some time, but who are not yet at an age when the so-called "maturing out" process (where older addicts are often motivated to make real efforts to rid themselves of the habit) is taking place. Secondly, the ratio of males to females was lower than that of other treatment facilities which may be an indication that there is a proportionately greater number of female addicts in the state. At this point, it is uncertain since the patients who came voluntarily or who were referred by the courts and other agencies and who were suitable for treatment in this unit were probably not representative of the total addict population. While the number of non-white patients was disproportionate to their number in the general population, the proportion of whites was high and indicates that, although the incidence of this problem is greater among the culturally-deprived minorities, it constitutes a serious problem for all groups.

The geographical distribution of the patient population, their educational level and occupational categories give us further information. Predictably, the largest proportion of cases treated at the unit came from Metropolitan Boston. Slightly over 70 per-cent were from the various areas of the city. Cases were distributed unevenly over the city with the largest numbers coming from Roxbury, Dorchester and East Boston. However, a range of other Massachusetts communities contributed to the case load of the Board treatment unit. Suburban areas including Arlington, Brookline, Canton, Dedham, Framingham, Medford and Milton sent a total of 8 per-cent of the patients who came for treatment. Two other groups of communities each contributed about the same percentage. These included cities close to Boston such as Cambridge, Chelsea, Revere, Somerville, and Watertown as well as cities throughout the rest of the state including Brockton, Holyoke, Lawrence, Lowell, Lynn and Springfield. The remainder of the patient load came from smaller communities as widely scattered as Williamstown and Hyannis.

Once again it must be emphasized that the present data does not allow for

firm generalizations, but the geographical spread and the range in size and type of community give us an indication that the problem has wide distribution in the Commonwealth and is not restricted to any particular group. Drug addiction has historically been, except in the South and before the passage of the Harrison Act, an urban phenomenon. It would appear that this may still be the case since a large part of the case load came from Metropolitan Boston. However, the fact that a sizeable percentage came from other communities leads us to make the tentative assumption that drug problems may be less an entirely urban matter in Massachusetts.

It is also possible that the problem may not be as closely restricted to groups at the lower levels of the socio-economic scale as is commonly believed. Some of the, as yet, incomplete data that has been collected shed some light upon this question. The determination of social class position is a complex matter and numerous indices of varying sophistication have been used by different investigators. However, although the data are not complete, they do contain the two variables — education and occupation — which have been shown by factor analysis to be the two most significant in any measure of social stratification. Looking at the educational and occupational distribution of the patients who came to the treatment center, the range is covered on each dimension. One patient had no formal education while others had graduate professional training, and every level in between from grade school through high school, through technical training to college was represented. The same holds true for occupations. These ranged from professional through white-collar and small business to skilled worker, semi-skilled and unskilled.

If one looks at education and occupation more closely, several things of interest emerge. First, predictably, in occupation there was a weighing toward the lower end of the scale. For example, in the category of semi-skilled and lower, the national average is around 40 per-cent while it was over 55 per-cent for the patient population. This figure is, in a sense deceptive however, as it included a number of young people who never had worked steadily at any job or who had low job skills but who came from a family background and original social class position which was several levels higher. In these cases, the use of drugs is correlated with downward mobility. Looking at the other side of the occupational coin, one-quarter of the patient population was found in the categories which include skilled workers, white-collar workers, small business men, managers and professionals.

There was also some variation in the educational picture. In comparison with national averages, the educational curve for patients was truncated. There were fewer of them at the lower and upper ends of the range. None were illiterate although one had no formal education, fewer had college educations and fewer grade school educations. What is of considerable interest is that a majority, over 56 per-cent, were high school dropouts. Most of these people left high school in their first or second year although some continued into the third year. It is evident that drug addiction and abuse is tied in with other social problems which are causing the nation such concern at the present time.

If education and occupation are combined as indices of social class position, it is interesting to note that between 25 and 30 per-cent of the patients fell squarely into the middle class as it is usually defined by sociologists and others.

To summarize then, research on the first year of operation of the treatment unit has demonstrated that there is a problem of some magnitude in drug addiction and abuse in the Commonwealth. The problem does not appear to be restricted to any one locality or group. Although there seems to be a higher incidence in the urban areas and among disadvantaged groups, others not suffering the same social disabilities are also subject to this unfortunate affliction. Further research will enable us to pinpoint the problem with greater precision.

CONCLUSIONS AND RECOMMENDATIONS

The drug addict of 1965 can be a baby born to an addicted mother, a fifteen year old boy, a thirty-five year old business executive, a doctor, a sixty year old schoolteacher, or a middle-aged housewife living in suburbia.

Drug addiction has become a major threat to the social, medical and public health of all persons living in Massachusetts. Time has erased the misconception that the problem of drug addiction is solely a lower class phenomenon only infecting a small segment of the community.

Traditionally, the average person in Massachusetts has always equated the the drug addiction problem with the criminal element, the poor and powerless, minority groupings, and "the great unwashed". Like all contagious diseases left untreated, the drug addiction problem has continued to grow and fester, burgeoning into all geographical areas, all age groups, and all strata of society in Massachusetts. It can no longer be relegated to the role of a secondary social problem in Massachusetts.

The leveling catalyst in the total drug addiction picture has been the widespread abuse of barbiturates and amphetamines, frequently easily attainable.

The United States Department of Health, Education, and Welfare pamphlet on Barbiturates as Addicting Drugs warns, "The excessive use of barbiturates is not only harmful to individuals, but presents a serious social problem." The pamphlet further cautions, "A grave but generally unrecognized danger lies in the addicted nature of barbital and its derivatives. In fact, these drugs hold an even greater threat than the opiates, since persons intoxicated with barbiturates are not only more confused mentally and emotionally, but also have poorer muscular coordination than opium addicts."

Physicians rely on drugs to assist in alleviating pain, to control infection, and to promote proper physiological functioning but man has an unfortunate, perverse tendency to turn products which are produced for his benefit into threats to his physical and mental health through abuse. Barbiturates and comparable sedatives are extremely important to the practice of medicine in this anxiety-ridden age.

Amphetamines are used medically as a stimulant, an appetite depressant, or as a mood elevator that promotes a feeling of well-being and euphoria. Because of their "euphoria" capacity, amphetamines have been misused by a growing number of immature adults and adolescents. Further, when narcotic addicts have found it difficult to obtain opiates of their choice, they have turned to amphetamines.

The widespread use of barbiturates and amphetamines is a mixed blessing. They must be available when we need them and, conversely, when they are dangerous they must be controlled by the proper authorities.

The following are conclusions and recommendations made by the Drug Addiction Rehabilitation Board in an effort to develop and structure the Commonwealth of Massachusetts "approach" to drug addiction:

I. The problem of drug addiction in Massachusetts must be met by a unified approach of progressive law enforcement coupled with realistic treatment and rehabilitation programs.

Separate, but supplementary, efforts of law enforcement and treatment and rehabilitation programs are necessary prerequisites for a total drug addiction policy in Massachusetts. A unilateral effort by either approach

to the exclusion of the other is inadequate.

II. The Drug Addiction Rehabilitation Board recommends that the number of treatment facilities in Massachusetts for drug addicts be increased. This will not only provide a larger bed capacity for addicts needing hospital care, but will also provide for additional outpatient and inpatient facilities throughout the state. The Drug Addiction Rehabilitation Board has recently received authorization and funds to set up a Narcotic Center and Out-patient Clinic in the city of Boston to give immediate aid to addicts and, also, to provide information, education, and vocational counseling. It must be remembered that good treatment is also good prevention.

A. The aftercare program of the Drug Addiction Rehabilitation Board must be more fully developed so that persons discharged from the treatment center located at Boston State Hospital be provided with more intensive assistance and support when they return to the comunity.

B. On the immediate horizon, the Drug Addiction Rehabilitation Board envisions the need for a halfway house to be located in the City of Boston giving residence to those addicts who have recently completed treatment at the unit at Boston State Hospital but who are, as yet, not sufficiently capable of functioning on their own in the community. Addicts could reside at the halfway house, leaving during the daytime to go to their places of employment and returning in the evening. They would be charged a reasonable fee commensurate with their earning capacity.

C. Vocational rehabilitation programs and a sheltered workshop are necessary ingredients to a long-range treatment plan, since many addicts do not have a trade or skilled background and need vocational counseling and guidance in order to be able to compete in community life.

III. Development of Informational & Educational Programs:

A. The Drug Addiction Rehabilitation Board recommends that the State Department of Education urge the superintendents of schools in all cities and towns to include in their high school senior cirriculum information and education on the dangers of drug addiction and abuse.

B. Intensive Area Prevention Programs - The Drug Addiction Rehabilitation Board recommends that cities and towns reporting a high incidence of addiction and abuse develop local prevention programs in order to alert and educate adults and adolescents to the dangers of drug addiction and abuse. Said programs would be structured on a "grass roots" level by coordinating the potentials and resources of existing programs and utilizing local community talent and support.

C. "Addiction Councils" could be set up in the affected areas, to be composed of persons representative of a cross section of the population in the community. These councils would direct and administer the programs. Said programs would be subsidized by state or federal funds. Local programs administered by the "Addiction Council" would be conditioned to meet the immediate needs and problems peculiar to to each area.

IV. The Drug Addiction Rehabilitation Board recommends the setting up of a committee to be composed of the American Medical Association, Council for the Aging, Public Welfare Authorities, and any other organization working with the elderly, to study the problem of addiction amongst this

age group and the need and feasibility of developing a separate program of drug distribution for them.

V. The Drug Addiction Rehabilitation Board encourages the American Medical Association and the Massachusetts Pharmaceutical Association in their efforts to help police this membership and restrict the indiscriminate prescribing and filling of drugs that could be addicting.

VI. The Drug Addiction Rehabilitation Board recommends that additional federal and state funds be appropriated to promote and encourage further research into the addicting properties of certain drugs, and to more fully explore the potentials and dangers of drug therapy.

— — The End — —

ANNUAL REPORT
1965-66

Commonwealth of Massachusetts
DRUG ADDICTION REHABILITATION BOARD
80 Boylston Street
Boston, Massachusetts

BOARD MEMBERS:

Alfred L. Frechette, M.D., Chairman
Commissioner, Department of Public Health

Harry Solomon, M.D.
Commissioner, Department of Mental Health

Mr. John A. Gavin
Commissioner, Department of Correction

Mr. John D. Coughlan
Director, Division of Youth Service

Mr. Lawrence D. Gaughan
Administrator

The past year has been one of consolidation and further implementation of the treatment program of the Drug Addiction Rehabilitation Board as authorized by Chapter 763, Acts of 1963.

During the preceding year legislation was enacted expanding the membership of the Board with the addition of the Director of the Division of Youth Service, Commonwealth of Massachusetts. The appointment of John D. Coughlan to the Board enlarged the representation of department heads who were most intimately concerned with the panoramic problem of drug addiction and abuse. It also serves to develop a closer working relationship between the Board and the aforementioned departments enhancing a more concerted and coordinated effort.

During June of 1966 it was necessary to move the administrative office from 8 Beacon Street, Boston, to 80 Boylston Street, in order to have office space for additional staff. The research section of the Drug Addiction Rehabilitation Board, under Dr. Victor Gelineau, was enlarged as of January 1, 1966, with the addition of a supervisor of research and a research assistant.

The treatment unit located at Boston State Hospital, directed by Dr. David Myerson, continued development of its services and is currently in the process of expanding inpatient facilities with an enlarged bed capacity. The Board, again, wishes to express its appreciation to Dr. Milton Greenblatt, Superintendent of the Boston State Hospital, for his continued assistance and encouragement.

Plans for an outpatient clinic to be conducted by the Department of Health and Hospitals, City of Boston, were also developed during the preceding year and implemented in the closing weeks of June 1966. This unit will be conducted by the Board of Health and Hospitals under a reimbursement agreement with the Drug Addiction Rehabilitation Board. It will be administratively responsible to Dr. Leon J. Taubenhaus, Deputy Commissioner of Community Health Services, Department of Health and Hospitals, and under the professional direction of Dr. Philip Solomon, Chief Psychiatrist, also of the Department of Health and Hospitals. Further explanation of the function of this unit is contained in the body of this report.

INFORMATION AND EDUCATION

The Drug Addiction Rehabilitation Board is authorized by Chapter 763, Acts of 1963, to develop education-prevention programs on drug addiction and abuse. The necessity for such programs is vital when it is considered how much gross misinformation and misconception is prevalent in the community today concerning the abuse of narcotics, dangerous drugs, and hallucinogenics. Only through such an educational campaign can the Board hope to inform the public about the harmful effects of these various types of drugs. Focus of the Board's educational program has been, primarily, aimed at the teen-ager and young adult population, attempting to make them aware of the full range of harmful effects, physical and psychological, that the use of narcotics, barbiturates, amphetamines, and hallucinogens can produce. As we stated in our initial annual report to the general public, the Board is of the firm opinion that the public, including the adolescent, should be educated to the dangers of drug addiction and abuse. It is recognized that, ideally, it would be best if this function could remain with parents, schools, churches, and specialized community services. Unfortunately, this attitude is not realistic and the Board has found it necessary to supplement existing information in the community with its own more comprehensive approach.

It should be noted that the first annual report which the Board issued in July of 1965 was accepted by the public with great interest and concern. We

received requests for copies of the first annual report from all over the nation, particularly colleges and universities, research bodies, mental health and public health groups, and from other colleagues in the treatment and rehabilitation field. Requests for additional educational material from the Board has been received from many high schools around the Commonwealth, civic groups, church groups, and even from industrial nurses working in large plants and companies. Requests to conduct training courses also have been received from organizations who work in the field of drug addiction and abuse. We have attempted to fill all these requests whenever possible, but we appreciate that much remains to be accomplished in this area.

The Board received funds, as of July 1966, to employ a health educator to develop educational, consultive, and community organization programs throughout the state in order to prevent drug addiction and abuse.

RESEARCH

The basic and immediate task of the research staff is to provide the Board with statistics and other factual data needed for administrative planning. They also must gather for the Board any information needed for development of the treatment and rehabilitation programs. Finally, there is long range research aimed at greater understanding of the social, psychological and medical aspects of drug addiction and abuse, and at determining the relative efficacy of different treatment procedures.

THE MAJOR AREAS OF RESEARCH

In addition to carrying out research on a day-to-day factual and statistical level as well as developing programmatic information and investigating long-range, basic scientific questions, the research falls naturally into three areas of concentration. These areas, while interconnected, require different approaches and techniques. The three distinct foci are:

1) The study of the addict as an individual.

2) The evaluation of the treatment process.

3) The study of factors and processes in the society which bear upon the problem of addiction.

In the study of patients who are involved with drugs, either as addicts or abusers, two sets of interlocking factors - the psychological and the sociological - must be taken into account. Clinical assessment and psychological testing of the individual addict's personality structure is needed along with life histories and basic demographic facts such as age, sex, education and race to more complex data about the individual's social development.

In the evaluation of the treatment program, a variety of measures of effect upon the patients as well as study of the organization and operation of the treatment unit must be carried out. Different kinds of information are needed when the societal aspect of the problem is studied. More epidemiological surveys to find out the extent of the problem in the Commonwealth and the effect of particular community settings on treated and released patients are the foci.

Although this is the general framework of the research effort, it is necessary to retain a flexible approach. Flexibility is desirable for a variety of reasons; first, experience often demonstrates that some kinds of research, while

intrinsically interesting, require too great an expenditure of resources and return too little useful information in relation to the time and effort used. Priorities must be established and certain types of research deferred for a later date. Secondly, the return from a given piece of research also must be measured against the staff resources available for the over-all program. Sufficient staff to implement the three major areas of research has been available only since January of 1966, and the bulk of the results has been gathered since then.

RESEARCH FINDINGS

A. Survey Data:

A survey of the prevalence of drug addiction and abuse in the Commonwealth has produced some preliminary findings. These are fully discussed in a special report which was released in May by the Drug Addiction Rehabilitation Board, and will only be summarized here. In 1930 a special Senate Commission published a report on drug addiction indicating that it was a problem that warranted action by the Commonwealth. The present survey is collecting more detailed data than has heretofore been available and is oriented toward obtaining as accurate an estimate as is possible of the number of addicts and abusers in the Commonwealth, as well as developing more sophisticated techniques for the continuous collection of epidemiological data.

A discussion of these survey findings must be preceded by an understanding that the study is not yet completed; thus, this sample of addicts and abusers is not completely representative of the entire addict population. The data in this survey to date have been gathered principally from the records of agencies whose function is enforcement of laws against the illegal use of drugs. Therefore, addicts and abusers who have been able to conceal their drug problem are not included in the data.

In our 1964-65 annual report we noted that addiction seemed to be a widespread problem in the Commonwealth. The survey findings, which give us a broader base of 1,048 cases from which to draw conclusions, indicate that our first impression was correct. Addicts and drug abusers come from all sections of Metropolitan Boston and from 125 other Massachusetts communities. Boston proper contributes 42% of the caseload while the rest are spread throughout the state in all kinds and sizes of communities. (Percentage totals in this report may, in some cases, not equal 100% due to rounding.)

Additionally, there is a fairly wide dispersion in the occupational and educational backgrounds of the people in this sample. The occupation of the addicts and drug abusers range from the category which includes professionals, executives and kindred occupations (3%); through skilled workers (15%); to unskilled and service workers (44%). The same thing is true for education - 8% have not finished eight grades while there is an expected concentration in the category of high school droupouts; 45% began high school but did not finish. On the other hand, 12% have had some college training.

Two other findings which are of significance are that (1) less than half of these addicts have any record of treatment for their problem and; (2) over one thousand people in the sample have close to 700 children.

In summary, the preliminary results of the survey show that the problems of drug addiction and abuse are widespread throughout the state, and that no one group, occupational category, or educational level has a monopoly on the problem

and that not enough receive any sort of treatment. It is also evident that many children will be growing up under a considerable disadvantage since they have parents with a problem of drug addiction or abuse. All of this, of course, means that the state is faced with a serious social problem with many ramifications.

B. Treatment Unit Data:

The research staff has worked closely with the clinical staff at the treatment unit at Boston State Hospital in a cooperative effort to obtain data that will be useful to the ongoing program. The function of the research has been discussed with clinical staff and considerable effort has been expended in a joint endeavor to develop comprehensive and clear recording forms for the collection of data that is both clinically useful and suitable for analysis by standard research techniques.

C. Socio-Economic Characteristics:

The patients who have come for treatment since the inception of the program at Boston State Hospital have been sutdied on a number of dimensions. The principal findings we have to date include demographic information on the patient's background such as age, sex, race, and psychological data including test results. Then there are the evaluations of treatment results on different dimensions.

In March of 1966 the Drug Addiction Rehabilitation Board met to review the operation of the unit which was opened as a 24-hour facility on November 9, 1964. In this meeting the Board considered the factors of patient load, the size of the addict population needing treatment, and the functions for which the ward was established. As a result of this review, the Board ruled that this treatment unit should retain its original purpose for developing new methods of handling the problem of drug addiction and that, in order to do this, it should not expand the case load above the number it is already treating. However, it is apparent that additional facilities will be needed to attack this problem at all levels.

From the opening date through June 30, 1966, some 282 people have contacted the unit for help. Of these patients, 208 were males and 74 females. As we noted in last year's annual report, this is a higher proportion of females than is usually found in addict populations elsewhere. Our data from the statewide survey shows that 15% of the cases are females. In contrast, the proportion of females (26%) who have come for treatment at the unit is considerably higher. It may be that there are proportionately more female addicts in Massachusetts and that the survey has not yet uncovered them. On the other hand, motivation for treatment may be higher among women and the existence of a therapeutically-run facility to help addicts may be attracting a larger proportion of women. This male-female proportion may be connected with the racial distribution of patients who come to us for treatment. Members of three racial groups have come to us for treatment: Caucasoid, Negroid, and Mongoloid. There is a predominance of white patients over non-white - 70% vs. 30% - but when race and sex are cross-tabulated we find that just under half (or 43%) of the women patients are non-white, and that females make up just under 40% of the total non-white group. Among the whites, on the other hand, females make up one-fifth or 21% of the total. It is not clear, at this point, why non-white females come for treatment in proportionately greater numbers than either white females or non-white males. Additionally, the criteria for admission to the treatment unit are therapeutic, having only to do with the patient's motivation and suitability for treatment and do not affect the race or sex distribution. Of all patients who have come for help, only a small number have been deemed unsuitable - less than 8% - so it is apparent that the range of patients in treatment is not due to the selection criteria use. Perhaps the most

interesting point about the sex-race distribution, however, is the fact that white males constitute the largest group of patients, making up 55% of the total.

Although there is a range in the ages (from 17 to 78) of patients seen at the treatment unit, they are predominantly a young group. The arithmetic mean age is 32.5 years and the median is 29 years. While 62 of the patients are over 40, there is a concentration in the 20 to 30 age bracket (125 cases), and 20 patients are under 20 years old. The large number of relatively young people in the sample of patients who have come to the unit is a predictable finding. Increasingly, addiction has made inroads into the younger age groups. The fact that there are 62 cases out of 282 over forty years old is, however, interesting. There is some belief among those who have worked with addiction that, as addicts grow older, a process called "maturing out" takes place. It is assumed that, over time, the addict gains small increments of maturity and also tires of the hectic round of seeking out drugs and the money to pay for them as well as the continual involvement with law enforcement authorities. It would appear from the number of addicts over forty who have sought help at the treatment unit that the so-called "maturing out" process does not take place as regularly as has been believed.

Addicts treated at the unit come from all educational and occupational levels. In education, they range from one patient who has had no formal schooling to four who have had graduate professional training - 10% have eight grades of schooling, 50% are high school dropouts, 16% have a high school diploma, and another 10% have either technical training beyond high school or some college.

The occupational distribution is about what we would predict from the educational range. Some of the addicts (3%) have never had a legitimate job for any appreciable time. A small number (4%) are professional athletes or entertainers; and 4% are students and another 4% are housewives; 5% fall into the category of professionals, managers, executives, and kindred workers. White-collar work such as sales, office work and the like, accounts for 18% while 14% are skilled workers such as electricians and welders. The largest category, however, includes those jobs which require little skill and pay the least. In jobs such as unskilled laborer, factory operative, domestic service, and so forth, we find 47% of the patients.

Of the patients who were inpatients, we have the results of intelligence tests. There is also a range here which runs from borderline and dull-normal to very superior intelligence. Most of the patients (71%) fall into the average or bright-normal categories (IQ score from 90 to 119). An appreciable number (14%) are of superior intelligence and have IQ scores of over 120. At the other end of the scale, 15% of the patients fall into the categories of borderline or dull-normal with IQ scores of 70 to 89.

D. Drug Use and Behavioral Characteristics:

It can be seen from the above data that, on some dimensions, these patients are very much like the general population. They are similar in age, sex, intelligence, education, and occupational skills, and include three racial groups. They differ significantly from the general population in other ways however. First of all, the addicts who have come to the unit for help do not represent those who have only recently become involved with drugs. On the contrary, the majority have long histories of drug use. Some 83% have been using drugs for more than two years, 52% of whom have been using drugs five years or more. Only 17% of the group have been using drugs less than two years.

What these figures indicate, of course, is that the clinical staff of the program is faced with treating people who, while they are generally young and on the whole quite intelligent, are confirmed addicts and who have been strongly affected by the drug-using way of life and all of its related problems.

These addicts have used a range of drugs and about one third are what might be termed multiple users (those who switch from one drug to another). The rest have a drug of choice, as it is termed, although they may occasionally use others is the drug of choice is not available. Most of these addicts have used mari uana at one time or another, but it may or may not have been their first contact with drugs. The drug of choice for 53% of this group is heroin while the rest are about evenly divided between the morphine and synthetic morphine substitutes and the exempt narcotics such as codeine in cough syrup. Amphetamines and barbiturates are also used by 16% of the people who are multiple users. Only a few of the patients who have been treated are involved with tranquilizers and the hallucinogens - a total of eleven.

If we combine the above findings with the results of clinical assessment and psychological testing, we see that in addition to long histories of drug experimentation, use and addiction, most of these patients have severe psychological problems. There are various schools of thought about the personality structure of drug addicts. There is not total agreement as to whether becoming addicted to drugs in and of itself constitutes a psychological disorder. Some workers in the field contend that accidental addiction, as with medically-addicted persons, does not indicate emotional disturbance. Others feel that non-medical, accidental addiction is possible if the victim comes from a subculture where drug taking is part of the social milieu just as the cocktail party is part of the American middle-class scene. Others contend that addiction at an early age may cause personality deterioration and prevent maturation, and the psychological problems one sees in an addict may be the <u>result</u> of the addiction rather than the cause. These questions are as yet unresolved and require more research before they can be settled unequivocally. Our data do not allow us to generalize to all addicts but careful evaluation of these patients we have worked with does indicate the presence of considerable pathology. There are some persistent trends which are in line with the findings of other treatment facilities such as the Public Health Hospital at Lexington, Kentucky. First, a large porportion (72%) display symptoms of what is called, in psychiatric terms, a character disorder - a range of symptoms which often can be quite complex, but in general can be seen as a basic lack of maturity. Those suffering from this problem have a low level of frustration, demand immediate and easy gratification, cannot accept adult responsibility, are without goals, and are quite anxious under any stress. Drugs represent to them an escape from any responsibility, the reduction of anxiety and a strong gratification of the senses.

A small proportion of the patients, slightly over 2%, show more neurotic difficulties while others (18%), have more severe components to their disturbance. When deprived of drugs they may display pathological suspiciousness or aggressive tendencies and severely distorted perception.

All of this indicates the severity of the problem of addiction and points up the fact that much research still remains to be done on the types of problems dispalyed by addicts, the etiology of addiction, and the best treatment modalities. It also emphasizes the fact that at this stage the clinical process has to be a long and intensive one (three to five years) and treatment goals modest and realistic.

E. Referral Sources and Procedures:

The patients who have come to the treatment unit have arrived there by different routes. A small percentage (11%) have come on their own, having read of the unit or heard about it through word of mouth. Others (31%) have been referred by physicians, hospitals or social agencies. A fairly large proportion (28%) have been referred by family, friends, other patients, or by their lawyers. Another large group (29%) come from courts, the police and correction agencies, including the Youth Service Board and the Suffolk County Department of Correction.

A total of 74 patients have come to us from the Municipal Courts, the District Courts, and the Superior Courts. The Municipal Courts which have referred patients include Boston and Lynn while four Superior Courts, Suffolk, Springfield, Milton and Bristol have used our facilities. Thirteen District Courts from Barnstable to Holyoke have referred patients. The largest number of referrals (50) have come from the District Courts. When a patient is referred to the treatment unit by the courts there are a number of alternative ways in which his case may be handled. There is, first of all, close consultation between the medical director and the head social worker and court personnel. The patient is then evaluated and a disposition is made that is in the best interests of both the patient and the community. The patient may be admitted to the unit as an inpatient or he may be placed on probation and treatment in the outpatient clinic made a condition of his probation. This disposition has worked well in a number of cases and has made for close collaboration between clinical staff and probation personnel. In other cases, the individual may be referred to another facility closer to his home for treatment. If the patient is adjudged to be a good candidate for treatment and no beds are available, he may be placed temporarily on outpatient care and put on a waiting list. Some patients, of course, are evaluated as unsuitable for treatment in the program due to reasons such as their lack of motivation or the difficult management problems they would present on a therapeutically-oriented ward. For some patients, a more controlled situation with a high degree of security is a more appropriate placement. These patients are frequently returned to the court with the recommendation that they be treated at Bridgewater State Hospital or Womens' Reformatory at Framingham.

Of the 74 patients referred by the courts, 12 have been inpatients and 23 outpatients, while 11 are on aftercare. Some 11 patients have been incarcerated and are, therefore, no longer in treatment. However, contact has been maintained with 4 of these patients and they will come back to the unit when they have finished their sentences. Another 4 patients have been referred to other facilities such as clinics closer to their homes and the medical director has acted as a consultant in their treatment. One patient is presently on the waiting list. A number of patients (11) were judged to be unsuitable for treatment at the unit and were returned to the courts.

The length of time that patients have stayed in the treatment unit as inpatients has varied. The optimum stay for a hospitalized patient has never been determined with any certainty in any treatment facility. For each patient a clinical judgment must be made that takes into account numerous and subtle factors - the addict's motivation, his ability to profit from the treatment program, his need to be gainfully employed to support his family, and a host of other factors. Additionally, the treatment unit is a small, experimental, therapeutically-oriented ward. Some patients on withdrawal from drugs become management problems and need a situation of greater restraint than the ward can offer. For these a long stay at the unit becomes inappropriate. In cases such as this, patients may be discharged from the ward and placed on aftercare treatment in the outpatient department or, if they are committed by a court, may be returned to the court for another disposition. It should be noted also that a patient who stays a short while on the unit and leaves the program will, in most cases, make up his mind to ultimately return

for further treatment. Motivation for treatment among drug addicts is notoriously fragile; therefore, the first contact and often succeeding ones, in many cases, must be devoted to establishing a relationship with the addict and bringing him to the point where he is ready to accept treatment and cooperate fully in the treatment program.

Considering the fact that the treatment facility has been in existence for so short a period and considering the difficulties of retaining addicts in a therapeutic situation, the unit has shown a remarkable ability to keep patients in treatment. Contact has been maintained also with many patients who have left, some because they have become involved in difficulties with the law for example, and many patients who have broken off treatment have come back. It appears that the clinical staff has been able to maintain an excellent degree of relationship with the patients and to bolster their motivation to continue treatment.

At present there are 15 impatients in the treatment unit. This is maximum capacity since the physical facilities of the unit are small and it is an experimental unit designed to develop and explore the best ways of treating addicts. There are, in addition to the patients in the unit, 54 patients on aftercare and 68 on outpatient treatment. This is a large caseload considering the limited size of the staff and the nature of the problem they are dealing with. Referrals and applications for admission to the treatment program continue to come in and the pressure to increase the load will undoubtedly grow in the future.

The treatment of drug addicts is a complex problem and is a process which not only takes place over a long period of time, but in which the goals of treatment must be realistic. As Dr. Warren Jurgensen of the Lexington Hospital has said, addiction is virtually the only disability where the patient enjoys his symptoms, which makes it doubly difficult to cure him.

It is doubtful at his point in time and with the present knowledge that we can properly speak of curing drug addicts. What we can work for, however, are smaller increments of success in helping the addict come to a greater understanding of what makes him take drugs and why he has to cahnge and to help him function in the community rather than be dependent upon it. Although the ultimate goal of the treatment program is for the patient to attain complete abstinence from drug use as well as to become a responsible and productive member of the community, we must be aware that relapse is to be expected. Treatment progress must be measured by less simplistic criteria than total abstinence. After treatment, if an addict stays off drugs for even a short time, works, and stays out of trouble, this is an advance even though he later may have to be rehospitalized and treated again.

We have tried to evaluate the results of this program on several dimensions. The addict's drug behavior is one. Another is his progress in therapy in terms of whether he has formed a productive relationship with treatment staff, has gained in his ability to control his symptoms in all areas as well as in his drug use, and has developed insight into the reasons for his problem with drugs. Another area of progress we have measured is the work performance of the patient. Not all patients progress at the same rate in all areas and, as the number of cases increases, we will be able to sort out the complexities of what influences are at work on each dimension. We now have data on over-all rates of progress.

On the dimension of drug behavior, patients were divided into four categories. The first category is made up of those patients who were recalcitrant to treatment and could never be successfully withdrawn from the drug but who continued drug-seeking behavior and returned to drugs at the first opportunity. This group comprised 10% of the total.

Another group cooperated in treatment and were successfully withdrawn but, upon release, immediately became readdicted and remain so at present writing. There are 37% of the patients in this category.

A somewhat larger group (42%) has made uneven progress. These patients cooperated in treatment, were withdrawn, and have either had one abstinence period of at least a month and then become readdicted or have been using drugs only occasionally. This is a group of patients who are motivated to change but who cannot resist the gratifications offered by drugs, and consequently fall back into a pattern of "chipping" or irregular use and ultimately readdiction. Many of these patients later return for further treatment.

Two small groups of patients are showing greater progress. One group (5%) have been abstinent from one to six months and are doing well on other dimensions, and 7% of the patients have been drug-free for six months or more.

Treatment of addicts is a multifaceted problem and, in addition to changing their drug behavior and helping them with psychodynamic problems, part of the effort is to help them become productive members of the community. Therefore, the program emphasizes the importance of work. Appreciable progress has been made on this dimension. A proportion of the patients (33%) are working steadily and, in most cases, at jobs appropriate to their skills and training. Another 22% are working intermittently but managing not to be a burden on the community. Some patients (11%) are not working but are making genuine efforts to find appropriate work. A proportion (34%), however, are not working and have again become involved with the drug way of life.

Other indexes of progress (or lack of it) in the patient's course through the rehabilitation program are his behavior and reactions to the therapeutic process. We have evaluated these on four dimensions: (1) Cooperativeness in treatment; (2) Relationship developed with staff; (3) Insight gained; (4) Control of symptoms other than drug behavior.

On the dimension of cooperativeness, we find that 33% of the patients demonstrated cooperativeness in the inpatient program and cooperativeness and regular attendance on the aftercare and outpatient programs. Another 10% have come irregularly to their appointments but otherwise have been cooperative. Still another 11% remain in touch with treatment personnel but primarily on a crisis basis - appearing for treatment only when they are under unusual stress. The remainder are officially classified as no longer active in the program since there has been no contact for three months. This statistic is deceptive, however, as it must be remembered that many patients return with increasing regularity to the program for help after long periods of absence.

When we examine the quality of the relationships formed by the patients with the clinical staff, we find that 11% of the patients are adjudged to have formed a productive and continuously-improving relationship. Another 43% are adjudged to have begun the development of a good relationship, while 46% have resisted entering into a therapeutic relationship.

Another indicator of what effect a treatment process has had upon a patient is his ability to contain the symptoms of his psychological problems, which may be manifested by violent acting-out behavior, stealing, irresponsibility, promiscuity, etc. Patients who have shown a marked improvement in this area total 6% while 34% show some improvement. The number of patients who are adjudged to have shown no improvement of this dimension total 60%.

Still another index of movement toward resolution of emotional problems is the amount of insight the patient achieves into the nature of these problems. A small proportion of the patients (6%) have achieved considerable insight into their problems. Another 33% have gained some insight and 61% have not.

ADDITIONAL ACTIVITIES OF THE RESEARCH STAFF

The research staff have participated in the general research effort of Boston State Hospital. This participation has been through meetings with other research personnel engaged in similar types of research and also through cooperation in a post-doctoral research training program. The National Institute of Mental Health has funded a program at Boston State in which recent doctoral graduates are trained by staff in research procedures in rehabilitation and in the mental hospital setting. The drug addiction research program is part of this project.

Communication with other professional colleagues in the field has been maintained and also with the Federal Government agencies concerned with the problem. Recent conferences between the Drug Addiction Rehabilitation Board and personnel at various levels at the National Institutes of Health have led to the development of a close working relationship on topics of mutual concern. Collaboration has been developed on a basis other than that of requests solely for reimbursement by the Federal Government for programs and projects. At the request of the Drug Addiction Rehabilitation Board a conference of those people in the various states who are grappling with the problems of treatment and evaluation research will be held by National Institutes of Mental Health in Washington, D.C., within the next few months. This is to be a small working conference of people who have had experience in the field and who need to exchange information on selected problem areas. Additionally, although our survey is now being carried out with the resources available to us from the Commonwealth, National Institutes of Mental Health has requested that we meet again with them in the near future to explore fully the possibility of developing a joint study in this area. Professional colleagues have requested permission to utilize some of the preliminary findings of the survey. They have noted that ours is the only systematically collected data on a statewide level available at the present time and that even the preliminary findings show significant results.

EXPANSION OF STATE HOSPITAL UNIT

As the above information has indicated, the present treatment unit located at Boston State Hospital was formally opened as of November, 1964 as an intensive-care pilot program emphasizing civil commitment and voluntary admittance procedures for persons having a problem with drug dependence. The program also offers an outpatient clinic and an extensive follow-up program when the patient returns to the community. Patients at the unit are accepted from a cross-section of the population of the Commonwealth in order that the staff gain experience from patients representing all strata of society. After sufficient experimentation and research, the treatment techniques and methodology developed at the unit are to be broadly applied in the community through additional treatment programs. As stated above, the caseload at the unit has reached a maximum capacity and there is a long waiting list. The unit currently has fifteen beds - twelve for men and three for women. These beds have been constantly filled, thus making it necessary to turn down many requests from the community and from the courts of the Commonwealth. The caseload of the outpatient clinic has been over one hundred cases for a period of eight months to a year. The responsibility for providing intensive treatment rests mainly on the medical director and social worker at the unit. Persons requesting a bed are placed on a long waiting list or, in many instances, have been referred to other sources. It has become increasingly obvious that the unit, at the present time, by virtue of limitations of size, bed capacity, and personnel, is unable to handle many of the patients referred for treatment.

Expansion of the existing facility at Boston State Hospital is indicated. Plans have already been made to acquire additional bed space in another building adjacent to the building in which the present ward is located. It will then allow the Board to utilize the existing fifteen-bed ward exclusively as a withdrawal ward where intensive care can be given the addict during this stress period. After three to four weeks when withdrawal is completed, the patient can then be transferred to a bed in an adjacent building where he would still receive close supervision and control; this would free a bed in the withdrawal ward for additional patients.

As has been previously indicated, the length of hospitalization varies with different individuals and some patients must be put on a "night hospital basis" for a period of several months before they can be returned to the community. This means the patient is allowed ground privileges or, in some instances, will leave the grounds possibly to be employed during the day, and will function normally in the community with the exception that he will return to the hospital in the evening. Supervision and control of the addict during this "night hospital" phase offers him an opportunity to be gradually eased back into the mainstream of community life. It gives him the support of being able to confer with the nurses and other professional personnel during the evenings, exchange experiences with someone who is sympathetic to him and his problem, and further allows him access to the medical director, if indicated. Additional personnel, in the form of another psychiatrist and head social worker, have been requested in the 1967 Supplementary Budget in order that both the withdrawal ward and the proposed "night hospital" unit will receive the supervision and attention which they demand.

SETTING UP UNITS AT BRIDGEWATER AND FRAMINGHAM CORRECTIONAL INSTITUTIONS

Young male patients ranging in age from 18-22 customarily need a longer period of "drying out" than is usually available to the average patient at the unit. This type of patient has presented, on occasion, difficult behavior and disrupted the atmosphere of the unit. It is obvious that the needs of these young, aggressive males demand that they be placed in a facility which is equipped to handle their difficult behavior but, yet, must be of sufficient size that hospitalization of the patient can be maintained for a longer period of time. The unit located at Boston State Hospital is not equipped to handle these difficult patients, especially those who need to be institutionalized for a period of approximately six months. It has become the practice, when these patients have been referred to the unit by the courts or through other community resources, to have them referred to either Bridgewater State Hospital or the Womens' Reformatory in Framingham. Both of these institutions are conducted by the Department of Correction in conjunction with the Department of Mental Health and have had experience over the years in treating addicts on both a voluntary and court referral basis.

It is the intent of Chapter 763, Acts of 1963, to set up treatment facilities for all addicts in Massachusetts but that diversified facilities be structured to handle specific types of patients. Creation of intensive care units at Bridgewater State Hospital or Womens' Reformatory in Framingham would reflect the intent of Chapter 763 that all addicts in Massachusetts should receive treatment for addiction whether they are incarcerated in a correctional institution or at liberty in the community. The present unit at Boston State Hospital with its minimum security facilities should not be expected to handle patients who would disrupt the therapeutic atmosphere and possibly constitute a menace to the safety of the staff or other patients. The setting up of intensive care units at Bridgewater State Hospital or Womens' Reformatory at Framingham would make available to the courts and the community medically-and psychiatrically-oriented facilities with the additional advantage of providing long-term care with security measures.

The proposal to establish treatment units at Bridgewater and Framingham was discussed with Commissioner John A. Gavin of the Department of Correction who, in turn, reviewed it at a meeting of his superintendents. It was the consensus of opinion that Bridgewater State Hospital and Womens' Reformatory at Framingham, by virtue of their treatment-oriented hospital affiliation and experience with addicts, were the best available sites for new drug addiction units. It was further recommended that the treatment staff of the said proposed units could be housed at Bridgewater, but could commute to Womens' Reformatory at Framingham to provide this institution with services as needed. It was also recognized that the professional staff of the proposed treatment unit could provide consultant services to the other institutions within the Correction Department. Requests for personnel to staff this unit were reviewed with members of the Board at a meeting on June 23, 1966, and received unanimous approval. Said positions were requested in the 1967 Supplementary Budget.

AMBULATORY CLINIC

On June 1, 1966, the Drug Addiction Rehabilitation Board entered into contractual agreement with the Department of Health and Hospitals, City of Boston, to conduct an outpatient clinic at the Public Health Unit, 20 Whittier Street, Roxbury, for the provision of services to those persons having a problem of drug dependence. The purposes of the clinic are: (1) to provide the public with accurate information on narcotic and drug abuse; (2) to determine the role of an outpatient clinic in the field of drug addiction treatment and rehabilitation; (3) to offer the addict an opportunity to secure treatment services voluntarily at an early stage of his illness; (4) to evaluate the role and rehabilitative potential of such a clinic when geographically located in an urban area with a high incidence of drug addiction; and (5) to observe and analyze the inter-functional relationship of the clinic within the integrated treatment and rehabilitative structure of the total Drug Addiction Rehabilitation Board Program.

In order to obtain these objectives, the clinic will offer a pervasive atmosphere of acceptance and understanding of the drug addict and his behavior; a general medical assessment of the addict utilizing other services of the Board of Health and Hospitals, if indicated; and a psychological assessment of the addict's condition to be made by a spychiatrist which will be followed, if indicated, by periodic psychotherapeutic sessions. The clinic will refer to the treatment unit at Boston State Hospital any addicts whose condition necessitates inpatient treatment, and will also coordinate the services offered by the clinic with those of other existing community resources - i.e., police, courts, social agencies, etc.

The outpatient clinic at Whittier Street is to be staffed by a half-time psychiatrist, a full-time drug addiction counselor, a full-time secretary, and a full-time attendant. At present the unit is undergoing remodeling, and staff recruitment is under way.

CONCLUSION

The word "drug" activates a reflex of fear and disapproval in the minds of some persons in the community today. Actually, the word "drug" is simply a generic term for any chemical agent. As the proper semantic connotation of this word becomes obscure, so, also, has the proper usage of drugs become obscure.

The first annual report issued by the Drug Addiction Rehabilitation Board in July, 1965, placed particular emphasis on the need for community awareness to the dangers of drug addiction and abuse. We noted, in that report, the widespread use of barbiturates and amphetamines, particularly amongst adolescents and young adults.

We also predicted the burgeoning use of psychotoxic drugs, also known as hallucinogens or consciousness-expanding drugs, such as LSD, peyote, mescaline, and psilocybin. Through improper usage these drugs can produce addiction, psychosis, or incur permanent brain damage.

The spectre of increasing drug addiction and abuse has become more alarming to the average person, particularly, since it is shrouded in so much misconception and misunderstanding. Since there is a temptation to lash out at anything which appears to threaten the well-being of the community, the Drug Addiction Rehabilitation Board must caution against any premature or precipitated action involving drug usage. To do so would be unfortunate and cause untold repercussions in the future.

The need for a calm, balanced, and rational approach to drug use was never more necessary than today, particularly so, since it is evident that each succeeding year will produce its own new and different crop of drugs. The valid and legitimate use of drugs must be recognized and encouraged, when subject to reasonable regulations and controls.

ANNUAL REPORT
1966-1967

Commonwealth of Massachusetts
DRUG ADDICTION REHABILITATION BOARD
80 Boylston Street
Boston, Massachusetts

Lawrence D. Gaughan
Administrator

BOARD MEMBERS:

Alfred L. Frechette, M.D., Chairman
Commissioner, Department of Public Health

Milton Greenblatt, M.D.
Commissioner, Department of Mental Health

Mr. John A. Gavin
Commissioner, Department of Correction

Mr. John D. Coughlan
Director, Division of Youth Service

At the conclusion of this fiscal year (1966-67), the Drug Addiction Rehabilitation Board has completed the initial stages toward the development of an integrated program for the treatment of drug dependence in Massachusetts.

The treatment program of the Drug Addiction Rehabilitation Board currently consists of three units - (1) a detoxification ward, night hospital ward, and an outpatient clinic at Boston State Hospital, Department of Mental Health; (2) a detoxification ward, dormitory, and outpatient clinic at Massachusetts Correctional Institution at Bridgewater, Department of Correction and; (3) a full-time outpatient service located at 20 Whittier Street, Roxbury, conducted by the Department of Health and Hospitals, City of Boston.

During the past year an additional eight-bed ward was opened at Boston State Hospital, enlarging the total inpatient capacity to twenty-four, expanding the office facilities, interviewing rooms, etc., as well as the physical facilities for the outpatient clinic. This entire treatment unit continues to be under the direction of Dr. David Myerson.

In September of 1966, the Drug Addiction Rehabilitation Board, in conjunction with the Department of Health and Hospitals, City of Boston, opened an outpatient service on the fourth floor of the Public Health Unit located at 20 Whittier Street, Roxbury. Its staff consisted of a half-time psychiatrist as clinical director, a full-time social worker, a secretary, a clinical attendant, and a Commonwealth Service Corps volunteer. Dr. Theodore Lindauer is the Clinical Director.

In January of 1967, a treatment unit for drug addicts was opened at the Massachusetts Correctional Institution at Bridgewater under the joint sponsorship of the Department of Correction and the Drug Addiction Rehabilitation Board. This unit was structured to handle male addicts needing a long period of inpatient treatment. At the present time, the unit has twenty beds, but after a period of further orientation and training this unit can be enlarged. The Director of this unit is Dr. Hushang Memarbashi.

The Board lost a valuable member in June of 1967 when Dr. Harry Solomon, Commissioner of Mental Health, retired. He was replaced, however, by Dr. Milton Greenblatt, the former Superintendent of Boston State Hospital, who has demonstrated avid interest in the treatment and rehabilitation of drug addicts.

The research section of the Drug Addiction Rehabilitation Board expanded its research activities to include the new unit at Whittier Street in Roxbury and, also, the Massachusetts Correctional Institution at Bridgewater. Dr. Victor Gelineau continues as the Director of Research in Drug Addiction. (Annual reports from each of the three treatment units are included in this report in condensed form.)

INFORMATION AND EDUCATION

The Drug Addiction Rehabilitation Board is authorized under Chapter 763, Acts of 1963, to develop education-prevention programs on drug addiction and abuse. As was stated in our previous annual reports, the Board is of the firm opinion that the general public should be educated to the dangers of drug addiction and abuse. During the past year we have tried to implement this philosophy by carrying out a number of speaking engagements at high schools, colleges, medical schools, hospitals, etc. We have received increasing demands from many professional bodies asking that the Drug Addiction Rehabilitation Board conduct seminars and institutes on the treatment and rehabilitation of drug addicts. In this regard, a number of local colleges have requested the Board's assistance in structuring day-long institutes on the hazards of using narcotics, dangerous drugs, and hallucinogens.

The members of the professional staff have also been asked to develop training seminars for other professional disciplines including social workers, psychologists, educators, and for correctional groups such as parole and probation officers. Community action organizations and civic groups have also contacted the Board about presenting local programs on drug addiction and abuse. At the present time, there seems to be a decreasing hesitancy amongst communities to admit that they have a drug addiction problem.

It has been difficult for the limited number of persons on the staff to fulfill the numerous requests which we have received. Once again, the Board is urgently requesting that the position of a health educator be included in the budget in order that we may serve those many requests which communities are making for assistance.

THE MAJOR AREAS OF RESEARCH

Since the establishment of the Drug Addiction Rehabilitation Board and the inception of the first treatment unit in November of 1964, one of the important concerns of the Board has been to carry out and encourage research on the problems of drug dependence and abuse. This research effort has two broad goals: (1) To obtain information of both a statistical and substantive nature on the drug problem that will be useful to the Board in its administrative and clinical planning; and (2) To carry on long-term research that will increase our knowledge of the problem and also contribute to the functioning of the treatment facilities. Several studies are being carried out in the following areas:

1) A continuing survey of drug dependence and abuse in the Commonwealth;

2) A study of the patients and the treatment process at the Drug Addiction Treatment Unit at Boston State Hospital;

3) The initiation of both extensive and intensive research on patients treated at the Whittier Street Clinic; and

4) The introduction of preliminary stages of data collection at the Treatment Unit at Massachusetts Correctional Institution at Bridgewater.

RESEARCH FINDINGS

A. The Survey of Drug Dependence and Abuse:

The survey of drug dependence and abuse is still in progress. Since the 1965-66 Annual Report and the survey report of June 1966, "Preliminary Results of a Survey of 1,048 Cases of Drug Addiction and Abuse in Massachusetts," an additional 1,000 cases have been recorded, bringing the total up to over 2,000 known drug addicts and abusers. (These cases have come from all sections of Metropolitan Boston and from 192 communities throughout the state.) It is anticipated that another 200-300 cases will be added to this number before data collection is terminated. These data are being gathered from correctional facilities, State Police, the Food and Drug Division of the Department of Public Health, state mental hospitals, and the treatment centers under the Drug Addiction Rehabilitation Board. The mental hospitals, in particular, are providing interesting data on individuals who have had no involvement with the law.

From the survey data, indications are that there are increasing numbers of "hidden" addicts and abusers from all socio-economic levels from throughout the Commonwealth. Many of these people are using the more "socially acceptable" drugs such as barbiturates, amphetamines, and tranquilizers as well as the potentially harmful non-prescription compounds. In many instances, they do not come to the attention of any legal authority or hospital; however, enough do to give some indication of the seriousness of the problem. There are those, too, who come to the attention of hospitals or other authorities but whose drug problem is not noted due to its presence being masked by other physiologic or psychiatric problems or due to the social stigma attached to being labeled a "drug addict."

Because of the magnitude of a survey endeavor of this type, it has been necessary to divide this project into several phases. At present, the research staff is nearing completion of the first phase which has included the collection of data from the above-mentioned facilities. In general, the staff at the various institutions have been very receptive and cooperative with our research efforts. Unfortunately, their records do not always contain enough material pertinent to our needs. However, with the data that is available, it will be possible to evaluate the scope and extent of the drug problem in the Commonwealth. Also, this experience has enabled the research staff to continually develop more sophisticated techniques for data collection than have heretofore been used.

Data analysis in depth has been restricted due to difficulties in obtaining programmer and computer time from already over-worked state facilities. Therefore, it was necessary to look elsewhere for resources. A small grant was provided for this purpose by the Medical Foundation, Inc. and programs are now being developed. By the completion of this phase of the survey in early fall, computer analysis of the data will already be underway.

Additional phases of the survey of drug dependence and abuse will be concentrated in learning of those cases which come to the attention of private physicians, private mental hospitals, general hospitals, and social agencies. Also, as Massachusetts and particularly Boston have numerous institutions of higher learning, there is ample opportunity to study the drug problem among college students. A pilot project is currently in the planning stages to investigate the prevalence of drugs on the campus.

B. Drug Addiction Treatment Unit - Boston State Hospital

During the past year, work has moved forward in the study of these patients treated at the Boston State Hospital Unit, the oldest of the Board's installations. Since this unit has been in operation for only two and a half years, we are still in the process of further refining the characteristics of those patients who profit most from specific modes of treatment. However, the available data are now being processed and will shortly be programmed for a computer which should give more definitive answers to these important questions. Over the past year, the research staff has continued to gather the basic statistical data for both the operational and the research efforts. These data show that the patient load has continued to increase. In the period from the opening of the unit to June 30, 1966, the unit had treated 282 patients. Present figures indicate that for the period since June 30, 1966, 173 new patients have come to this installation for help, making a total of 455 patients. In addition to the 173 new patients, there were also 35 patients who had been previously treated and who were admitted this past year as inpatients. A total of 96 patients were treated on an inpatient basis; of these, 49 were also treated as outpatients as part of the total outpatient census of 156 cases.

A number of points about the patient population treated during the past year are of interest. The first is the geographical area of residence. Considering the fact that the treatment unit is located in Metropolitan Boston, it is expected that a large proportion of the cases treated at the unit will come from Boston Proper. Also, although addiction is becoming more widespread, the greatest prevalence is still in highly urbanized areas. In this regard, 63% of the patients who come to the unit for treatment live in Boston Proper. The problem is spread throughout the city. The sections contributing the greatest number to the patient population were East Boston and Roxbury, followed by Dorchester and then the Back Bay. The other sections of the city contributed an approximately equal number of patients who came for treatment. (It should be noted here that figures derived from the patient load at the treatment unit do not constitute a true measure of the prevalence of drug problems either in the whole city or in any given section. They represent simply those cases who either by court order or through voluntary action have sought treatment.)

Looking at cities on the Boston periphery, approximately 10% of the cases come from places such as Cambridge, Malden, Newton, Revere, Somerville and Quincy. Suburban communities including Arlington, Braintree, Brookline, Framingham, Lexington, Milton, Wayland, Weston, Westwood, and Winthrop add another 8%. Thus, the population concentration of Greater Boston produced 81% of the patient load at this treatment unit. In the remaining 19%, there is a range of communities such as Chicopee, Holyoke, Lawrence, Lowell, Lynn, and Springfield as well as smaller communities including Acushnet, Beverly, Billerica, Chelmsford, Marblehead, Marlboro, Middleton, Millis, Oxford, Randolph, Rockland, Saugus, South Hadley, Walpole, Whitman, and Williamstown. Once again, it should be carefully noted that these data do not give a precise picture of the extent and/or distribution of the problem nor do they indicate that the communities cited necessarily have a greater problem than any others. This data indicates, amongst other things, that the treatment unit is serving a wide geographical area within the Commonwealth.

Information on a number of other demographic variables has been collected on all patients treated at this installation. One of these variables of interest is that of age. There is increasing evidence from different sources that drug abuse and dependence are becoming more and more problems of the younger age groups. This assumption is borne out by the data on the patients treated in the past year. The mean age for the patients is 27.66 and the median, 26. This contrasts with a mean of 32.5 and a median of 29 for those patients treated prior to this past year. Obviously, this is not a startling drop nor is it conclusive evidence that this problem is afflicting more young people; however, it is supportive evidence for a trend observed in other contexts. The largest single age category of patients is that which falls into the 20-24 year bracket (58 cases), while twenty patients were under 20 years of age with the youngest being 15. Drug problems are not, however, the exclusive province of the young as a total of forty patients were ages 25 to 30 and fifty-five were over 30 years of age, seventeen of whom were over 40, the oldest being 65.

On the variables of sex and race, the distribution is not much different from previous years. White males form the largest group - 100 of the 173 patients. White females number 25, which is roughly the usual ratio in other treatment facilities throughout the country. Male negroes number 31 while female negroes number 13. The ratio of females to males is slightly higher in the non-white group. A small number of cases - four male patients - fall into the category of other non-whites; i.e., mongoloid, Puerto Rican, etc.

The religious distribution of the patients treated at this unit does not vary too greatly from that of the general population. There were 103 Catholics, 45 Protestants, 6 Jews, 8 who professed to have no religion, 2 who fell into other religious categories, and 9 who did not state a religious affiliation.

Information on educational attainment was obtained on 168 of the patients and again, as in the past, the predominant characteristic of the education data was that of the high school drop-out. Those who left school between the ninth and twelfth grades number 78. The next largest category is that of high school graduates (36). At the lower educational ranges are two who had no formal education, five who had less than eight grades, and eleven who completed eight grades of education. At the other end of the scale, there are thirteen patients who had some training, usually business or technical, beyond high school, nineteen who had some college, two who have college degrees and two who have professional degrees. This makes a total of slightly over 40% of the patients who have a high school education or better, 20% of whom have more than a high school education.

If this educational information is coupled with the figures on the occupational distribution among unit patients, it becomes evident that these patients are distributed among several socio-economic strata. The spread of occupations runs from unskilled through entertainers to professionals. If the nine housewives are excluded, 76 individuals have occupations at the skilled level or higher. This is 46% of the total. Not all patients have a high occupational level, however, as the categories of semi-skilled, unskilled, and service workers make up the rest or 54% of the total.

Some other characteristics of these patients are also of interest. In an examination of the marital status of this group, 80 of the patients are single. Given the relatively young age level, this is not an unexpected finding but it is still a lower rate of marriage than that of the general population. Of those who are or have been married (93), almost half (45) have been divorced or separated. Although divorce and marital break-up are not uncommon in this society, a rate of almost one out of every two marriages ended by divorce or separation is certainly excessive.

Another facet of this matter is the fact that these patients have children. This group has a total of 209 children. The number of children per family is lower than the national average, being 2.1 for this patient population. However, this still represents a large number of children who are growing up in an environment that is less than optimal and many of whom may cause problems for the community at a later date.

Patients came to the treatment unit through a variety of channels. One of the principal sources of referral to the installations are the courts. A total of 34 patients were referred to the treatment unit by a number of different courts including the Superior Courts of Suffolk, Dedham, and Cambridge and the District Courts of Dedham, East Boston, Cambridge, and West Roxbury. Other court jurisdictions have also referred patients to the unit when the need arose. Probation officers have been particularly active and instrumental in referring patients. Many individuals have also been referred by patients who have, themselves, been treated at the unit. A variety of other sources including police, social agencies, hospitals - both general and psychiatric, physicians, and families have sent patients to the treatment unit in the past year.

The varying lengths of time that patients have been hospitalized are the result of a number of factors. Addiction is a complex problem and each case has to be carefully assessed on an individual basis for the most profitable treatment program. Some patients need fairly long periods of hospitalization before they can be considered satisfactorily improved to function in the community while others can be placed on an aftercare basis sooner. Still others may prove to be management problems and have to be transferred to a more structured setting for treatment. Some may prove to be so recalcitrant to treatment that they have to be referred back to the courts for a different disposition. All treatment facilities working with addicts have encountered these same problems and there is no one ideal solution. The only reasonable procedure is to develop a program of treatment for each patient that seems best to suit his or her problems after careful analysis of these problems by the clinical staff.

Considering the relative youth of these 173 patients, it is interesting to note the length of time they have been using drugs. The largest group - 63 patients - are those who have been using drugs from two to five years. Two other groups of patients have been using them for even longer periods; 38 patients have been using drugs for five to ten years and 34 patients have been using drugs for <u>over</u> ten years. The remainder of the patients have used drugs for under two years. It is evident from these figures that a considerable proportion are hard-core addicts who have had long experience in the illicit use of drugs while there is another group who have had a much shorter experience with drugs but who are nevertheless addicted.

When one looks at the drugs used by this group of addicts, there is a wide variety. Combinations are also quite common. Some use heroin exclusively while others regularly use such combinations as heroin and morphine, heroin with barbiturates and amphetamines, morphine or synthetic equivalents and cocaine, morphine and LSD, exempt narcotics and barbiturates, marijuana and LSD, and endless other combinations. Heroin alone or in combination with other drugs is the drug of choice for the largest proportion (78) of these patients. The next largest group (34) prefers to use morphine or an equivalent synthetic narcotic alone or in combination. Next are the barbiturate and exempt narcotic addicts with almost equal proportions - 19 and 18, respectively. There are also those who prefer amphetamines even though they use other drugs, and some are addicted to tranquilizers while there are a few who sniff glue. Finally, when questioned on their drug use and drug of choice, some will admit to an indiscriminate use of any substance that will help alleviate their high anxiety level and give them a feeling of euphoria.

There is no clear-cut picture of which drugs are most commonly used by addicts when they first begin taking drugs. However, our data indicate that there is no particular drug that a potential addict will try nor does there seem to be an inevitable progression from one particular drug to another. It would appear that the first drug an addict tries will be the drug that is most readily available in his particular environment - his neighborhood or community. (A progression which has been observed in the large urban slum setting has been from marijuana to heroin.) Pure chance also enters into the equation.

It has not been possible to obtain information from all of the patients on their drug of introduction as they frequently do not remember especially if they have a long and complicated drug-abusing history. For those addicts on whom information is available, the most common drug of introduction was the group of exempt narcotics such as codeine or its equivalent found in cough syrup or the opium found in paregoric. There were 36 patients who began with this. The next most common drugs of introduction were heroin (22 cases) and amphetamines (20 cases). Marijuana was used by seventeen addicts, and the remainder started on morphine, barbiturates, tranquilizers, LSD, or glue.

The wide range of drugs actually used with regularity, and the number of different drugs which were the first the addicts came into contact with is indicative of the lengths to which the potential addict will go to find a chemical solution to his problems as well as the wide availability of illicit drugs in our society.

C. Whittier Street Clinic:

Since the Whittier Street Clinic opened nine months ago, the research and clinical staffs have been collaborating in gathering data designed to give as complete a picture as possible of the social and psychological factors that go into the process of drug dependence and abuse. Patients entering treatment at this facility are administered a series of standardized psychological tests including an intelligence test (Wechsler Adult Intelligence Scale), the Minnesota Multiphasic Personality Inventory, and the Tasks of Emotional Development Test. From these three instruments, a profile of each patient can be developed which allows for comparisons with other groups upon whom these measures have been standardized.

Two other dimensions are explored in depth with each patient - the sociological and the psychodynamic. Sociological variables that are systematically studied include the socio-cultural characteristics of the community setting from which the patient comes and the structure of the patient's family. Instruments have been developed for recording this data which, when supplemented by clinical data obtained in the process of therapy and by the above-mentioned psychological tests, will enable the staff to gain an understanding of the addicts' problems on a depth level.

As these sociological instruments have only been in use for a short time, the total number of forms completed is too small to show any significant trends. However, with an N of 22, some of the following characteristics have been noted: 73% of these patients reported coming from stable neighborhoods; 64% indicate that the average family income in their neighborhoods is under $6,000 per year; 41% of the patients reported coming from neighborhoods of varied religious preferences, 23% each from predominantly Protestant or predominantly Catholic neighborhoods, and the remaining 14% from Jewish neighborhoods. Community activity patterns appear in the following order: street corner and drugstores, church- or synagogue-centered activities, neighborhood bar, and social clubs. The patients' activity patterns showed that 45% frequented drugstores or the street corner; however 26% reported no pattern of activity even though their neighborhoods did have active community patterns. From the available family data, an item of interest is that 80% of the patients coming from families with three or more children are in the middle position in the sibling order.

The basic purposes behind the type and range of data gathered at this clinic is to attempt to isolate the more important psychological and sociological variables and to determine the nexus between them. As noted elsewhere in this report, drug dependence and abuse are becoming widespread at several socio-economic levels, and it is important to understand the relationship between the social context in which this drug abuse takes place and the psychological processes involved in the individual illness. This kind of information is useful not only for a better understanding of the problem itself but also for the treatment process. Information gathered at this clinic will, of course, be integrated with that from other installations.

D. The Treatment Unit at Massachusetts Correctional Institution, Bridgewater

At this installation (which is only five months old), data are being gathered on patients which are comparable to the data collected at the Boston State Hospital and the Whittier Street, Roxbury units. Basic demographic and social history materials are collected on each patient upon admission. In addition, patients are administered the same psychological tests (Minnesota Multiphasic Personality Inventory and the Wechsler Adult Intelligence Scale) that are given at the other units. In addition, clinical assessments and progress of treatment reports are systematically kept on each patient. As yet, it is premature to report on any of the results of tests and assessments on these patients but the following statistical material is available.

Since the inception of this facility in January of 1967, 41 patients have been hospitalized - all of the patients are male. As in the other treatment facilities, the patients come from all sections of Boston and from communities outside the metropolitan area. The largest group of patients from Boston proper (15) comes from East Boston, but other sections of the city are also represented. The communities outside Boston which have sent patients to this installation include Attleboro, Chicopee, Chelsea, Everett, Lowell, Lynn, Medford, Revere, Stoughton and Worcester.

Once again, we note that the patients are predominantly young people. The median age is 23. The mean is somewhat higher (27.6) due to the presence in this group of several patients in the higher age brackets; e.g., 58, 65, 66, etc. Of the forty-one, 24 are under 25 years of age and two of these are under 20. Only four of the patients are over forty (these four are all Chinese) and nine patients fall into the 25 to 29 year bracket while four are in the 30 to 40 range.

The racial distribution at this unit is not unusual, there being thirty-three white, four negro and four Chinese patients.

The marital status of this group of patients differs somewhat from the Boston State group. Twelve out of the forty-one are married while four are divorced and one is separated. This means that less than half of these men are or have been married and, of those married, the divorce and separation rate is closer to that of the population at large. This may, of course, be due to the youth of the majority of these men.

The educational picture is close to that found in other groups of addicts. The largest proportion - 25 - are high school drop-outs. A fair proportion, eight out of forty-one (20%) have a high school or higher education and, at the other end of the scale, an equal proportion have eight grades or less. If graphically displayed, the educational range would approximate a statistically normal curve. Due to their youth and the fact that many are high school drop-outs, twenty-eight of these patients fall into the lower occupational ranges; unskilled, semi-skilled, service workers and two who have never worked at all. The remaining thirteen are divided between various kinds of skilled workers and white-collar workers. There are no professionals.

The pattern of drug usage among the Massachusetts Correctional Institution at Bridgewater patients does not differ greatly from what we have found elsewhere. Only four of the group have used drugs less than two years. Sixteen have used drugs for two to five years, fourteen from five to ten years and six for over ten years. Data is not available on one patient. It is apparent from these figures that this

is a group whose drug dependency is of long-standing nature. As with other groups, these addicts have used a great range of drugs. Heroin is the leading drug of choice - twenty-one of the patients prefer it. Five more use heroin in combination with other drugs such as barbiturates, exempt narcotics and morphine. Three of these patients use morphine primarily, one of whom used it in combination with cough syrup. Three use barbiturates exclusively while another four use barbiturates in combination with other drugs. Two addicts use exempt narcotics, cough syrup and paregoric, by choice and there is one addicted to tranquilizers and one user of amphetamines. One patient admits to using anything and everything he can get his hands on. As in the data from the Boston State installation, it is notable that there is a range of drugs used with a narcotic still the most common drug of choice and barbiturates increasing in use while the users of the hallucinogens are still only a small proportion of the total case load. Looking at the drug of introduction, exempt narcotics again lead with barbiturates next, followed by amphetamines, then marijuana, heroin and morphine.

Nine of the patients are committed to the treatment unit at this point under Chapter 763, Section 111A; two for a period of observation while awaiting trial, and seven for long-term treatment. The other patients are committed for periods of observation and withdrawal under Chapter 123, Section 80 - a voluntary commitment.

ANNUAL REPORT - BOSTON STATE HOSPITAL TREATMENT UNIT

From June 30, 1966 to June, 1967, the treatment unit at Boston State Hospital has evaluated close to 188 patients. They were referred to the unit from the courts including the police, by other addicts, from other hospitals, and from other social service agencies. Of these patients, about 25% were accepted for inpatient care and 60% were accepted for outpatient care. The remaining 15% were either referred to other institutions or were refused because they did not appear to be addicted. At the present time, there are approximately 160 patients under active treatment - 110 of whom have contacted the unit since July of 1966. The rest are continued from previous years.

With the accrued experience, the unit has clarified its goals of treatment. From the initial evaluation, each patient is assessed with two questions in mind: (1) How far can the patient be educated towards acquiring useful work skills and using them constructively in the community? and (2) How much support does he need in maintaining sobriety and controlling his need for dangerous and illegal drugs? There is an extremely wide variety of responses among the drug-addicted patients. There are some patients who are so fragile that keeping the patient alive becomes the main therapeutic goal. On the other extreme, there are a few patients who not only achieve complete sobriety but also acquire work skills which they use constructively in the community. Most patients fall in between these two extremes and show improvement in terms of their social behavior but need continual medical and psychiatric care to control their illegal drug use.

The aim of helping these individuals towards achieving their best possible community adjustment brings the unit staff into close contact with diverse community agencies - the various correctional offices, the vocational and educational counsellors, family service workers, welfare agents, to name a few. It is felt that the success of the work-oriented program depends upon the staff's ability to coordinate the professional skills that each worker can offer. One of the most promising programs has revolved around the rehabilitation of a number of addicted parolees. In several instances, the encouraging success has depended on the closest cooperation between the unit staff, several parole officers assigned to the unit, and various work counsellors who have interested themselves in these patients. One of the hopes is to refine and extend this approach in the forthcoming year.

There have been several changes among the unit staff: Dr. Albert Samarweera has joined the staff as Senior Psychiatrist; Mr. Jack Sarmanian, Head Psychiatric Social Worker, replaced Mr. Andre St. Pierre who left the unit to join the newly-formed Whittier Street Clinic; Mrs. Eileen Henriques joined the staff as a part-time Social Worker; and Mrs. Elizabeth Johnson continues as the Supervisor of the nursing service. There have also been additions to the clerical staff.

The unit staff continues to participate in conferences and educational programs sponsored by schools, churches, and other organizations on both a state and community level. Under the sponsorship of the National Institute of Mental Health, the unit participated in a national conference where the aim was to standardize a record-keeping system to be used by drug addiction treatment centers throughout the country.

In the past year, the capacity of the unit has been increased from twelve to sixteen beds. Occasionally, because of heavy pressure to admit patients when these beds were filled, the unit has been able to use beds in other sections of the State Hospital. As the staff enlarged, it was necessary to move the outpatient office space from the Administration Building to the first floor of G-Building, which has provided space for offices as well as providing room for an additional eight beds for a halfway house or night hospital ward.

ANNUAL REPORT - THE WHITTIER STREET CLINIC

The Clinic opened September 19, 1966 in quarters on the fourth floor of the Health Unit at 20 Whittier Street in Roxbury. Its staff consisted of a half-time psychiatrist as clinic director, a full-time social worker, a secretary, a clinic attendant, and a Commonwealth Service Corps volunteer.

During the period of some nine months of operation, direct services were provided for 66 persons, 85% male, whose mean age was 24 and whose median was 22. The age range was 13 to 53, with 21% under 20 years of age, 60% between 20 and 30, and 12% being between 30 and 40 - the remainder being over 40 years of age. Eighty-three per cent of the total patient load was white and 17% Negro. The patients came both from Boston (61%) and its environs (39%). All Boston neighborhoods were represented, the highest numbers being found in East Boston, Dorchester, Roxbury and Roslindale. The highest suburban counts were from Cambridge, Newton, Brookline, and Salem, but all of the following towns were represented: Medford, Dedham, Revere, Ashland, Framingham, Hingham, Needham, Wilmington, and Burlington. The patients' education ranged from a fourth grade dropout to a professional school graduate. Roughly two-thirds of them had not completed high school, yet in the 18% of them who took the Wechsler Adult Intelligence Scale (WAIS), the average I.Q. was 106 and the median, 103, of a range from 85 to 140. Approximately 80% were either in unskilled or semi-skilled employment. There was a wide range of drugs used from glue to heroin to harmaline, while slightly less than 25% of the patients indicated no drug of choice. Most had taken a variety of drugs at one time or another - some in surprising combinations such as LSD and opiates. Heroin was the drug of choice in only 23% of the patients although an additional 20% had used it at some time or other. Thirty-eight per cent had used marijuana, although only 7% listed it as their drug of choice. Forty-three per cent had used barbiturates, but only 9% preferred it. Twenty per cent had used amphetamines heavily, although few claimed it as their drug of choice. Some 15% used hallucinogens regularly. There was a history of heavy consumption of alcohol in only four cases, so that the population is clearly a distinct one from those of the alcoholism clinics.

The clinic in its first nine months of operation offered individual counselling to those persons who voluntarily came for help, and there is little doubt it was quite effective in reducing a patient's drug dependency by substituting the support of a meaningful human relationship in psychotherapy. It enabled others to face their denial of the problem and go to Boston State Hospital for medical withdrawal from drugs; this progress was maintained only so long as they were followed up after withdrawal in the clinic setting.

The local Negro community was somewhat slow to utilize the facilities of this new drug addiction treatment clinic. Initially they were suspicious of the function of the clinic and whether its location in their community was a reflection upon them. After considerable community interpretation, however, any hostility that might have been in evidence seemed to dissipate. The Back Bay Banner, a Negro-sponsored publication, interviewed both the administrator of the total Drug Addiction Rehabilitation Board program and the clinic director of the treatment unit. The newspaper then published a very sympathetic article on the role of the treatment clinic, interpreting its function, its philosophy, and its attitude toward drug addicts.

Much of the clinic's work had to be focused upon getting known to the Boston community, and, to effect this purpose, numerous meetings were held by the clinic director and the social worker. These meetings also had the important function of educating people in other fields regarding the nature of drug addiction about which there is much ignorance and misinformation. All of the following organizations were contacted during the past year: The Youth Activities Commission; the Neighborhood Youth Corps; the Commonwealth Service Corps; the U.S.Public Health Service; the National Institute of Mental Health; the Visiting Nurses Association of Greater Boston; the City of Boston Recreation Department; the Special Services Division of Parole; the Department of Probation; the Police Academy; Drug Addicts Anonymous; the Massachusetts Council on Narcotics and Drug Abuse; the Parker Hill-Fenway Association; Brookline and Winthrop High Schools, the Simmons School of Nursing; Brandeis University; Harvard University Health Services and numerous others that space limitations prevent mentioning. The clinic's social worker spent Thursday mornings conducting group therapy with addicts at either Deer Island or Dedham Jail. He also attended the staff conferences every Wednesday morning at Boston City Hospital and the case conferences at Boston State Hospital every Thursday afternoon. The clinic director attended the monthly meetings of the Boston City Hospital Psychiatry Department's Executive Committee, and he spent a six-week period teaching second-year Harvard Medical School students an introduction to clinical psychiatry and drug addiction. The clinic attendant and the Commonwealth Service Corps volunteer were taught to give the WAIS test by Dr. Jean Arsenian of Boston State Hospital, and they attended a course given by Dr. Rickard at Children's Hospital to learn how to give a special projective test, the Tasks of Emotional Development(TED) test. Since late winter, they have begun to routinely give those two tests plus the MMPI (which is scored by the research staff) to all clinic patients. In the past month, they have been to the new treatment facility at Massachusetts Correctional Institution, Bridgewater, to administer the WAIS and MMPI to the patients confined there.

The geographical division of the patients closely parallels the preliminary results of the Commonwealth-wide survey, which disclosed some 40% of the drug users come from Boston and another 27% from its suburban environs. This being so and because the practicalities of the drug culture respect no niceties of township boundaries, it would be wise to continue a clinic policy of acceptance of all persons who live in the Greater Boston Metropolitan Area - especially since this facility is the only outpatient clinic currently functioning in the whole Commonwealth.

It seems clear that the clinic has made a good beginning and is now established, but now much more must be done. The demands of a second year will require expansion of staff and of space. The gradually increasing duties and patient population will necessitate making the position of clinic director full time as well as hiring another full-time social worker. A clinical psychologist should be added to the staff both to supervise and carry out the extensive testing and to work in therapy in patients - which requires at least a half-time appointment. Using a strictly medical model for the rehabilitation of drug addicts has proven plainly unworkable elsewhere, so that the clinic is envisioned as the beginning of a larger, community-wide approach that must provide a wide spectrum of services and a variety of programs. Already, there is a need to remain open at least one or two evenings a week.

The clinic director spent a week in New York last winter to explore the current pioneering programs in this area and came away with new ideas that might be explored. The New York experience suggested a variety of inventive ways to produce rehabilitated addicts. All of them give much reason for increased optimism about the effectiveness of therapy with drug-dependent persons. What is required of us is not slavish acceptance of any or all of these programs, but the imagination and critical ability to see which ones can be used in the Greater Boston Metropolitan Area and in what manner they can be adapted to our resources and to the nature of our drug population. It is unrealistic to expect that any one approach can treat addicts. The natural history of drug dependency cannot be contained in the traditional framework of the agent-host medical model. It must involve the social pathology of the drug culture and the psychopathology of the family unit as well. Only when the therapists who treat addicts overcome their own mental sets about this illness can they then effectively confront the challenge of treating "the only illness that is a pleasure to have."

ANNUAL REPORT - MASSACHUSETTS CORRECTIONAL INSTITUTION AT BRIDGEWATER

On January 27, 1967 a Drug Addiction Treatment Unit was opened at Massachusetts Correctional Institution at Bridgewater jointly sponsored by the Department of Correction and the Drug Addiction Rehabilitation Board.

It is the intent of Chapter 763, Acts of 1963, to structure treatment facilities for all addicts in Massachusetts thus necessitating that diversified units be developed to handle specific types of drug addict patients.

The creation of an intensive-care treatment unit at MCIB made available to the courts a facility equipped to handle difficult patients but yet of sufficient size that hospitalization can be maintained for a long period of time - patients are accepted at MCIB on a court commitment or voluntary basis.

The treatment program at this unit consists of a detoxification ward located within the prison hospital where twenty-four hour medical and nursing services are available during the addict's withdrawal period. Following detoxification the patient is transferred to a twenty-bed dormitory where he is immediately accessible to the offices of the doctor and social worker. A large day room is located beside the dormitory.

The treatment program at MCIB consists of weekly group therapy meetings, individual counselling and the development of good working habits. Since the unit is only six months old much remains to be accomplished. High on the priority list is the development of education courses for addicts who have not obtained a full high school education. As noted in the research section of this report, many of the addicts who have been treated at MCIB are school drop-outs.

Close contact with the families of the addicts has been instituted with wives and parents of the addicts being encouraged to visit regularly. In addition, the social worker at the unit has made home visits giving advice and consultation and, in general, attempting to ready the family for the return of the addict. In this respect, the unit at MCIB is working toward total family involvement and total family therapy.

The unit at Massachusetts Correctional Institution at Bridgewater also has served to reinforce the existing program at Boston State Hospital by making available to them a facility they can utilize with patients who become management problems. With some patients, after a period of hospitalization within a well-structured unit, their behavior improves so they can be returned to a minimum security facility.

CONCLUSION

Whether by design or accident, the field of treatment of drug dependence on a nation-wide level is too frequently characterized by a lack of communication and sharing of information. In addition, because of the increase of the problem of drug dependence throughout the country, the pressure on treatment and restoration programs has increased. The haste to produce "a panacea program" has sometimes resulted in confusion, insufficient planning, and a lack of evaluative techniques in the development of organizational structure.

The best antidote to these deficiencies is an exchange of information and knowledge with increasing emphasis on the integration of services and the unification of resources.

No single program, discipline, or department bears the total responsibility for the treatment of drug dependence. In varying degrees it is shared by all. By the same token, no single program, discipline, or department has been able to develop treatment modalities adaptable to all types of addicts. Until we have acquired such a definitive body of knowledge on how all types of drug dependence can be treated, it is imperative that responsible persons in the field of the treatment of drug addicts allow maximum exposure of their efforts for the mutual benefit of all.

ANNUAL REPORT
1967-1968

Commonwealth of Massachusetts
DRUG ADDICTION REHABILITATION BOARD
80 Boylston Street
Boston, Massachusetts

Lawrence D. Gaughan
Administrator

BOARD MEMBERS:

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Commissioner, Department of Public Health

Milton Greenblatt, M.D.
Commissioner, Department of Mental Health

Mr. John A. Gavin
Commissioner, Department of Correction

Mr. John D. Coughlan
Director, Division of Youth Service

During the fiscal year (1967-68) the Drug Addiction Rehabilitation Board conducted treatment and rehabilitation units at Boston State Hospital, Boston City Hospital and at Massachusetts Correctional Institution at Bridgewater.

The treatment facility at Boston State Hospital consisted of a detoxification ward, separate wards for male and female inpatients (total beds 25), office and interviewing rooms, and a large outpatient and day care center. The program at this treatment facility is under the direction of Dr. David Myerson.

The Department of Health and Hospitals of the City of Boston conducted a full-time out-patient unit at 20 Whittier Street, Roxbury. In addition, the professional staff at this unit also serviced a clinic one day a week located in East Boston Public Health Building. The staff of the Whittier Street Treatment Unit consists of a full-time psychiatrist, Dr. Frank Haendel, two full-time social workers, a part-time psychologist and a medical secretary.

The remaining treatment unit, located at the Massachusetts Correctional Institution at Bridgewater accepts court commitments and voluntary admissions. The setting is on a medico-correction basis and structured to provide patients with vocational and educational training. A fully staffed hospital is immediately adjacent to the treatment unit and its facilities are available on a 24 hour basis. The Director of this unit is Hushang Memarbashi.

On May 1, 1968 the Drug Addiction Rehabilitation Board unanimously voted to expand its treatment and rehabilitation program in the western part of the state. "If the goal of the treatment unit is to help the addict make his way in the community then the services that support him should be readily available in his neighborhood." (1964-65 Annual Report of the Drug Addiction Rehabilitation Board, p. 1)

One of the most serious problems that has impeded the full connotation of a treatment program for drug addicts in Massachusetts is geography. At the present, treatment facilities currently authorized by the Drug Addiction Rehabilitation Board have all been located in eastern Massachusetts. These three units have all treated addicts who have lived in the western part of the state. Intensive aftercare of the patient returned to the western part of the state has been difficult and ineffective.

The Board therefore recommended that a 15 bed inpatient unit be located at Northampton State Hospital, Northampton, Massachusetts, which will accept patients on a voluntary and court-committed basis. This unit will offer detoxification services to those persons who are addicted and need to be withdrawn from drugs in a scientific and painless manner. It will also offer outpatient services to those persons in the immediate community who have a drug abuse problem and need weekly consultation with a trained therapist.

The Board also voted to set up half-time ambulatory clinics in Springfield and Pittsfield. These half-time centers are to be conducted under medical auspices and will give assistance to persons in their immediate areas. They will also refer persons needing in-patient service to the treatment unit at Northampton State Hospital.

An area in which the professional staff has been active is that of consultation with various members of the community, particularly educators, who are working with young people in an attempt to prevent the spread of drug abuse. Numerous seminars, inservice training courses and meetings have been held with educators, religious leaders and others charged with guiding young people. In addition to consultation services, staff members have given a large number of public lectures on drug dependence to a wide variety of community groups in different sections of the state. Requests for such service to the community continue to come to the Board and staff members continue this activity. The staff has also, of course, maintained contact with professional colleagues in the field of drug dependence, both locally and on the national level. The

staff has profited by this exchange of information and even greater communication is anticipated in the future.

Selected Demographic Findings

Some of the demographic information on the patients at the three treatment units of the Board; Boston State Hospital, the Whittier Street Clinic, and the Bridgewater Correctional Institution Unit will be presented here.

Boston State Hospital

The Drug Addiction Treatment Unit at Boston State Hospital has treated a total of 318 patients during the fiscal year of 1967-68. This is a considerable increase over the number of patients seen at the unit during the previous year of operation.

Of the 318 patients treated, 101 were admitted as inpatients and the remaining 217 were admitted on an outpatient basis.

Of the inpatient population, 18% were admitted as a condition of probation under Chapter 123, Section 86, 4% as a condition of parole under the same section and 10% were admitted voluntarily for an indefinite amount of time, also under Section 86. Of the 68% outpatient population seen at the Boston State Hospital Unit 60% were seen on a no-commitment out-patient basis and 8% were seen on a no-commitment out-patient basis, but as a condition of probation.

In looking at the geographical distribution of the patient population at Boston State Hospital Unit, it should be pointed out that fewer of the patients came from Boston than in the previous year. Last year 63% of those patients who were admitted to the Unit lived in Boston as contrasted to 51% in the current fiscal year. An additional 27% of the cases live in the northeastern section of Massachusetts with the greatest proportion of the cases coming from the larger cities and towns such as Cambridge, Lowell, Lynn, Malden, Medford, and Somerville and Arlington. Other smaller cities and towns make up the balance of the 27%. Another 15% of the cases reside in the southeastern part of Massachusetts, e.g., New Bedford, Brookline, Newton, Quincy and Waban, with a somewhat lesser proportion coming from smaller towns. Three percent of the patients came from the central area of the state and the remaining 3% were from other New England states.

Although 95% of the cases admitted to Boston State reside in the northeastern and southeastern parts of the state, the dispersion of cases away from Boston proper indicates a definite trend away from a concentrated urbanized problem and towards an all-encompassing problem throughout the Commonwealth.

Demographic data such as age, sex, race and education will be compared with that from patients admitted to the other treatment facilities in tabular form at the end of this section. Suffice to say here, a typical addict coming for treatment at Boston State Hospital would be a white male, average age 25, and a high-school dropout. His place of residence most likely would be in the Greater Boston area. The treatment unit at Boston State Hospital is currently located on the entire second floor of the Building. It is comprised of a withdrawal ward, separate wards for male and female patients, and offices for the professional and clerical staff.

The unit has also received a grant from the National Institute of Mental Health to train social workers and nurses.

Whittier Street Clinic

The Whittier Street Outpatient Clinic located in Roxbury has treated some 74 new patients during the past year. Referrals to this clinic are made from courts, the police and correction agencies, through family or friends, as well as through physicians, lawyers, and social agencies.

Of the total number of patients, 95% came in on a no-commitment voluntary basis while 5% came in on a no-commitment voluntary basis, but as a condition of probation. Two of the patients had been withdrawn at Boston City Hospital Psychiatric Unit and were given follow-up treatment by the professional staff at the clinic.

The area of residence of the patients who were admitted to the clinic is mainly from Boston Proper with a total of 62%. The surrounding communities of Cambridge, Somerville, Arlington, Everett, Revere and Watertown, Bedford, Saugus, and Winchester contributed 27% of the patients. Only 11% of the patients reside in smaller southeastern cities and towns. The average addict coming for help at the Whittier Street Clinic is a white male, 24 years of age, with less than 12 years of education.

The clinic now in its second year of operation continues under the supervision of Boston City Hospital Psychiatric Department to provide direct treatment to patient's with a drug dependency problem. Treatment involves psychiatric and casework counseling on an outpatient basis and intensive aftercare. Recently beds at Boston City Hospital's Psychiatric Services Inpatient Unit have been assigned to this clinic for drug detoxification. This added service should greatly increase the number of patients coming to the clinic. It should also promote continuity of treatment as well as help hold patients in treatment.

In November 1968, an interviewing room in the quarters of East Boston Mental Health Unit at 79 Paris Street was made available to clinic personnel. This move was felt necessary so that treatment would be more accessible to patients in an area where there is a serious drug problem. A day a week has been devoted by clinic staff to counseling patients at that facility. Current plans involve expanding this clinic from a part-time to a full-time clinic.

The past year has seen an increase in staff important to the continuing growth needs of the clinic. Where formerly the clinic had a half-time psychiatrist directing it, there now is a full-time psychiatrist. Also a full-time social worker has been added to the clinic staff.

A major task undertaken this past year has been to begin to more specifically define our goals in treatment and describe therapeutic techniques as to their usage and effectiveness. The resulting modality of treatment gives strong support to the assumption that to be able to reject drugs the patient must progress toward the five following goals:

1. He must build up substitute satisfactions to be found in human relationships, work, marriage, sex.
2. He must find adequate outlets for his pent up emotions.
3. He must develop problem solving techniques to cope with his day to day problems.
4. He must expand his tolerance threshold for hardship, for perservering, for putting off immediate gratification.
5. He must move from an attitude of helplessness and passivity to one of agressiveness and assertiveness.

Massachusetts Correctional Institution at Bridgewater

At the Massachusetts Correctional Institution at Bridgewater 153 patients have been hospitalized on a voluntary basis under Chapter 123, Section 80, and an additional 152 patients have been committed to the institution through the courts during the fiscal year 1967-68. Of the 153 voluntary admissions, 16 of the individuals had multiple admissions which leaves a total of 128 separate voluntary admissions.

Of the 152 court-committed patients, 18 had multiple admissions leaving a total of 131 separate admissions from the courts.

Of the court-committed addicts, 66% (or 86 cases) were committed under Chapter

111A; one under Section 4, 12 under Section 6 (observation), 72 under Section 8 (probation) and 1 under Section 9 (parole). In addition, three cases (2%) were committed under Chapter 123, Section 62 for a period of time of up to two years. Of the 32% who received temporary commitments from the courts, 21% were committed for 10 days observation (Chapter 123, Section 79), 6% for 15 days observation (Chapter 123, Section 80) and 5% for 40 days observation (Chapter 123, Section 77).

The geographical distribution of patients who were admitted on a voluntary basis differs from those who are admitted from the courts. Of the voluntary patients, 60% reside in the larger cities of Cambridge, Fall River, Bedford, Lynn, Waltham, and Somerville. Smaller cities and towns in the northeastern area also contributed to the patient population. The southeastern section of the state has contributed 9% of the voluntary patients while 2% came from the central areas, 2% from the western area, and 2% were from outside of New England.

Of the court-committed patients, 48% came from Boston proper. The northeastern section contributed 26% with the majority of patients coming from the larger cities of Cambridge, Lowell, Somerville, Lynn, Malden and Medford. Somewhat smaller cities and towns contributed the balance of patients. Thirteen percent of the patients came from 10 towns in the southeastern district. The central area supplied 2% of the patient population while the western area supplied 4% of the patient population. Four percent were from out of state.

The profile of the addict who needs a structured environment and who is court-committed to Bridgewater is similar to that of the patient seen at Boston State Hospital and at Whittier Street Clinic. His average age is 24, he is a white male and a high school dropout. The addict who is admitted to Bridgewater on a voluntary basis is somewhat older, with an average age of 28. He is also a white male with less than 12 years of education.

The following tables compare demographic factors on the patients at the three treatment facilities:

A G E *

	Boston State N=318	Whittier St. N=74	Bridgewater (ct. committed) N=131	Bridgewater (voluntary) N=128
Ages 14-25	70%	73%	70%	55%
26-30	12%	8%	15%	22%
31-65	17%	16%	15%	23%

This table indicates homogeneity with respect to age at the three treatment installations with the exception of the Bridgewater voluntary patients. This group is comprised of a number of older, hard core addicts which is reflected in the mean age.

The following table shows the mean and median ages of all patients at the three installations:

M E A N & M E D I A N A G E S

	Boston State N=318	Whittier St. N=74	Bridgewater (ct. committed) N=131	Bridgewater (voluntary) N=128
Mean Age	25	24	24	28
Median Age	22	20	23	25

In contrasting the mean and median ages of the patients with those of the previous year, it becomes evident that there is a somewhat younger patient population at the three treatment centers. In the 1966-67 fiscal year the mean age at the Boston State Hospital Unit was 27.6 and the median was 26, while for the fiscal year 1967-68 the mean age is 25 and the median is 22. At the Whittier Street Clinic the mean age has remained constant at 24 but the median has dropped from 22 to 20 years of age. At the Massachusetts Correctional Institution at Bridgewater the mean age for 1966-67 was 28 while the median was 23. In the fiscal year 1967-68 the mean age for the voluntary cases is 28 and the median is 25. However, as can be seen by the table, the mean age of the court-committed cases is 24 and the median is 23.

E D U C A T I O N *

	Boston State N=318	Whittier St. N=74	Bridgewater (court ct.) N=131	Bridgewater (voluntary) N=128
Less than 12 years	56%	68%	71%	73%
High School Graduate	24%	23%	15%	17%
Some College or Technical Training	17%	6%	7%	6%
College Graduate	2%	0%	.007% (1 case)	0%

It is interesting to compare the educational levels of the three installations. It can be seen that there is a much higher educational level of those patients admitted to Boston State Hospital. Of the total patient population at Boston State Hospital, 19% have had some college or technical training beyond high school or have graduated from college. This compares with 6% at the Whittier Street Clinic and 7% at Bridgewater who have had any training beyond high school. The admission procedures at all of the Board's treatment units are based entirely on appropriateness of the treatment facility for each individual patient, and demographic characteristics are not criteria for admission.

R A C E

	Boston State N=318		Whittier Street N=74		Bridgewater (court ct.) N=131		Bridgewater (voluntary) N=128	
	Male	Female	Male	Female	Male	Female	Male	Female
White	71%	16%	68%	17%	82%	-	74%	-
Non-white	12%	1%	12%	3%	18%	-	26%	-

This table shows that the majority of patients treated for drug abuse are white males. The Boston State Hospital Treatment Unit and the Whittier Street Outpatient Clinic have relatively the same ratio of whites to non-whites in their patient population. However, at Bridgewater there is a greater proportion of non-whites.

* Columns do not total 100% because it was not possible to obtain complete data in all of these cases as some of these individuals did not remain in treatment long enough for clinical staff to gather complete data on them.

ANNUAL REPORT
1968-1969

Commonwealth of Massachusetts
DRUG ADDICTION REHABILITATION BOARD
80 Boylston Street
Boston, Massachusetts 02116

Lawrence D. Gaughan
Administrator

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During the fiscal year 1968-69, a new dimension was added to the existing program of the Drug Addiction Rehabilitation Board with the rapid growth and development of community action and educational programs.

In the last year, over 45-50 cities and towns have organized coordinating bodies in their communities in order to treat the problem of drug abuse. A recommendation that communities develop coordinating bodies was strongly urged in the 1964-65 Annual Report of the Board. Many of these communities developed their programs completely on their own initiative, while others received consultative advice from the Board. In cities and larger towns the principal function of the coordinating body was primarily to:

1. Plan, establish, strengthen and improve local programs for the treatment and rehabilitation of persons involved with drug abuse. Priority should be given to the development of these essential services:

   a. in-patient services (including diagnostic and acute withdrawal)

   b. out-patient services (including diagnostic)

   c. intermediate care services (including partial hospitalization, halfway houses, self-help groups)

   d. twenty-four hour emergency services

It has been the experience of the Board that when a treatment facility is conducted in conjunction with a community action program, it will affect 25 out of 50 persons in a community who have a problem with drug dependence. A treatment facility conducted independently will only reach approximately 5 or 10 persons cut of 50 persons who have a problem with drug dependence.

On March 12, 1969, the Board sponsored one of the largest conferences on drug addiction in the nation at Framingham, Massachusetts, with 1600 persons in attendance. The principal speakers at the conference were Sidney Cohen, M.D., Chief, Center for Studies of Narcotic and Drug Abuse, National Institute of Mental Health, Bethesda, Maryland, and G. Joseph Tauro, Chief Justice of the Superior Court, Commonwealth of Massachusetts.

On May 1, 1969, an intensive-care treatment unit for voluntary and court-committed patients was opened at the Massachusetts Correctional Institution for Women at Framingham. This 25-bed unit will offer detoxification services to those females who are addicted and need to be withdrawn from drugs in a scientific and painless manner. This medico-corrective setting will also offer out-patient services to those persons in the immediate community who have a drug abuse problem and may voluntarily seek help. A halfway house located in Boston is also available for those patients who need assistance to readjust in the community.

During the past year, it became evident that the five treatment centers were serving different types of populations. Although many of the demographic variables show a relative consistency, there are some differences which can be attributed to the populations themselves. Below are listed the demographic variables for each of the treatment centers followed by a brief summary of the characteristics of the population at each unit.

Demographic Data

The demographic data on the five treatment units are presented below. Included are data on inpatients and outpatients at the Boston State Hospital, outpatients at the Whittier Street and East Boston clinics, and data on those patients at the Massachusetts Correctional Institutions at Bridgewater and Framingham. The total number of admissions at all of the above centers is 1,723, which represents a 150% increase in the number of patients seen during 1967-1968.

I. Boston State Hospital

During the fiscal year 1968-69, the Drug Addiction Treatment Unit at Boston State Hospital treated 497 patients. Of this number, 111 were admitted as inpatients and 386 were treated on an outpatient basis.

Of the inpatient population, 20% were committed under Chapter 111A, Section 6. An additional 23% were committed under the same chapter, Section 8, as a condition of probation, and 2% were admitted under Section 9, as a condition of parole. The remaining 55% were admitted voluntarily for an indefinite period of time under Chapter 123, Section 86.

Of the out-patient population, 75% were admitted under Chapter 111A, Section 2, and the remaining 25% were admitted under Chapter 111A, Section 8, as a condition of probation.

As in previous years, there is a definite progression away from the central urban areas into the surrounding communities. The concentration of cases from the Boston area has decreased from 51% in 1967-1968 to 39% in 1968-1969. The greatest proportion of cases, 28%, reside in the northeastern area with the largest number of individuals residing in Cambridge, Arlington, Somerville, Everett, Malden, Chelsea and Haverhill. The southeastern area contributed 24% of the cases with the major areas being Newton, Brookline, Brockton, Quincy and New Bedford. The central section of the state contributed 4% of the cases with the concentration of cases in the Worcester area. An additional 4% reside in the western area, the principal areas being Springfield and Holyoke.

Another significant factor in the changing pattern of drug abuse is the decrease in average age. For the 1968-1969 fiscal year, the average age was 22 with a median age of 20. This represents a 3-year decrease in average age since last year. Looking at the average age over a 5-year period, it should be pointed out that there is a 10-year decrease in average age of the drug user. This factor indicates that the pattern of drug abuse is continually shifting to the younger age group.

For the Boston State Hospital Unit, the largest percent of abusers are found in the under 19 age group, i.e., 39% of the cases. Two 14-year old patients were referred to the adolescent unit for special services provided for their age group. The second largest category of drug users is the 20-25 age group with 43% of the cases. These two age groups include a total of 82% of all the cases treated at this facility. Another 10% of patients are in the 26-30 age group. Only 7% of the patients are over 30 years of age.

The picture has also changed regarding sex and race; a larger proportion of females are being treated. In the previous year, 17% of the patients at the Boston State were females while for the present year 27% were females. More non-whites have come to the unit for treatment this year, i.e., 27% of all cases as compared with 13% last year.

The educational levels are similar to those of previous years. Sixty-one percent have less than 12 years of education, compared with 56% last year. There is a

slightly smaller percentage of high school graduates, 18%, as compared with 24% last year. This could be attributed to the large percentage of dropouts, which amounts to 80% of those with less than 12 years of education. Sixteen percent of the patients have some college while 5% have graduated from college or have had advanced training.

Sixty percent of the patients prefer heroin although many of them use it in combination with other drugs. The second largest category of drugs used is amphetamines and hallucinogens, 17%, while another 6% of the patients used amphetamines in combination with barbiturates and hallucinogens. A small number, 4%, preferred morphine, and another 4% were hospitalized for LSD use. Five percent of individuals who were treated at Boston State used marijuana only, while 2% used barbiturates only, 1% used codeine and 1% were glue sniffers.

II. Department of Health and Hospitals: City of Boston

A. Whittier Street Clinic

The Whittier Street Clinic treated 444 patients during the last year. This is an overwhelming increase in patient load from 74 during the 1967-68 fiscal year. These patients were referred to the clinic by private physicians, lawyers, social agencies, or through the courts or correctional agencies.

Individuals coming to the clinic on an out-patient basis reside mainly in the Boston area and the surrounding communities north of Boston. A total of 56% reside in Boston, while 30% live in the communities of Cambridge, Somerville, Revere, Chelsea, Arlington, Lawrence, Lowell, Salem and Lynn Ten percent of the cases reside in the southeastern communities of Newton, Brookline, Framingham, Canton and Brockton. Only 1% reside in the central area, while 3% of the individuals traveled from Springfield to obtain treatment at the clinic.

The age distribution of patients seen at the out-patient clinic differs in many respects from last year; fourteen percent were under 19 years of age. An additional 54% were between 20-25 years of age. These figures total 68% as compared to 73% in the previous year for the same age group. Those individuals in the 26-30 age bracket have doubled from 8% to 16% this year. Individuals over 30 represent 15% of the total caseload as compared with 16% in the year 1967-1968. The mean age has remained constant at 24, although the median age has risen from 20 to 22 this year.

Eighty-four percent of the patients who sought counseling at the clinic were males. This represents a 4% increase over last year's male patients. There has been, however, a more significant change in the racial distribution of cases. The major difference has been in the percentage of non-whites seeking treatment. During the year 1967-1968, 15% of the total caseload were non-whites, while for the current year 31% were non-whites. This shows a 100% increase in the non-white population seen at the clinic.

The most marked difference in characteristics of the drug dependent individual seen at the clinic has been in educational level. While in the previous year 68% have had less than 12 years of education, in the current year 46% have this amount of education. Of this number, 43% are school dropouts and the remaining 3% are still in school. The percentage of high school graduates has increased from 23% to 27% during the last year. Those having some college or a college degree comprise 25% of the total patient caseload as compared to 6% in the previous year. Of the 25% of youths of college age, 18% have dropped out of school.

At the clinic 89% of all admissions were found to be heroin users. Four percent of the patients used amphetamines and hallucinogens, while 3% used morphine in

combination with other drugs. Another 2% used combinations of amphetamines, barbiturates and hallucinogens. Only 1% used codeine and an additional 1% used marijuana only.

B. East Boston Clinic

The East Boston Clinic was opened as a full time out-patient treatment facility in November, 1968. Since its opening, 124 patients have been seen on an out-patient basis. The greatest proportion of patients, 42%, reside in East Boston, while 33% reside in other areas of the city. An additional 18% of the patients live in the northeastern section of the state with the major areas of concentration being Revere, Everett, Chelsea and Winthrop, and a somewhat smaller number of cases from Lowell, Lawrence, Somerville, Winchester and Peabody. The southeastern section contributed 6% of the cases with Newton and Brookline having the greatest proportion of cases and Framingham and Dedham a lesser proportion. Only one case was admitted from the central area and one was seen from the western section of the state.

Ninety percent of the caseload at East Boston were males and racially the greatest proportion of cases, 83%, were white.

The age distribution is similar to the other treatment centers, with 57% in the 20-25 age bracket. An additional 26% are in the under 19 age group. This totals 85% in the under 25 age group. Ten percent of the patients were in the 26-30 age group. Only 7% of the individuals treated were over 30 years of age. Both the mean and median ages of the patients seen at the clinic are constant at 21.

The educational distribution at East Boston was somewhat different from the other treatment facilities. While 58% had less than 12 years of education and 33% were high school graduates, only 9% had some college or advanced technical training. This is in sharp contrast to the 21 and 25% of college affiliated individuals seen at the Boston State Hospital and Whittier Street clinics, respectively.

The drug of choice was heroin, with 91% use among the patients. This is consistent with the drug of choice at the other out-patient clinic at Whittier Street. An additional 3% of the patients used amphetamines and hallucinogens, and 2% used morphine and other drugs. Another 2% used barbiturates and only 1% used codeine, while another 1% used LSD and marijuana.

III. Massachusetts Correctional Institution at Bridgewater

During the fiscal year 1968-69, the total number of admissions to the Massachusetts Correctional Institution at Bridgewater was 586. Of this number, 417 were admitted through the courts; 193 under Chapter 111A, Section 6, (10-day observation) and 221 under the same Chapter, Section 8, (probation). Under Chapter 123, Section 80, 169 patients were admitted voluntarily.

The basic demographic data on the court-committed and voluntary patients at the Massachusetts Correctional Institution at Bridgewater are similar. The heaviest concentration of individuals treated at Bridgewater reside in the city of Boston; i.e., 44% of the voluntary patients and 35% of those who were court-committed. The northeastern section contributed 25% of the voluntary patients and 21% of the court-committed patients, with the major areas of concentration being Medford, Revere, Malden, Cambridge, Everett, Somerville, Framingham, Lawrence, Lynn and Beverly. The southeastern section contributed 26% of the court-committed patients and 27% of the voluntary patients. The major areas of concentration were New Bedford, Brockton, Quincy, Weymouth, Framingham, Taunton and Hyannis.

The central area of the state contributed 6% of the court commitments and 1% of the voluntary admissions to this facility. Worcester and Fitchburg were the major areas of residence for the court commitments; in addition, Worcester furnished 1% of the voluntary patients. The western section of the state contributed 6% of the court-committed cases, the major areas being Springfield, Holyoke and Chicopee. Of the voluntary patients, 2% resided in the Springfield, Ludlow and Granby areas. Seven percent of the voluntary patients were from out-of-state.

The racial distribution shows a change from that of the previous year. For the court-committed individuals, 86% were white and 14% were non-white compared with 82% white and 18% non-white last year. A more significant increase in white voluntary admissions is noted with 83% compared to 74% in 1967-68.

At the Massachusetts Correctional Institution at Bridgewater, 36% of the court commitments were in the 19-year age group. An additional 48% were in the 20-25 age bracket. These two age groupings total 84% compared to 70% last year. Nine percent of the court-committed individuals were 26-30 years of age. Those individuals over 30 represent 7% of the total as compared to 15% during the 1967-68 fiscal year. The mean age for the court-committed patient has dropped from 24 to 22 during the past year and the median age has dropped from 23 to 20.

Of the voluntary patients, 20% were in the 19-year age group. The group between 20-25 comprises 43% of the population. This group comprises 63% of the total caseload as compared to 55% in the same age groups for 1967-68. The 26-30 year group represents 21% of the voluntary patients. Only 16% of the patients were over the age of 30 as compared to 23% during the previous fiscal year. The mean age of the voluntary patient has dropped from 28 to 26 and the median age has dropped from 25 to 22.

The educational distribution of the voluntary patients has remained relatively constant with that of the 1967-68 fiscal year. Seventy-three percent of the voluntary patients have less than 12 years of education, 18% are high school graduates and 6% have some college training.

The educational level has changed somewhat for the court-committed individuals. Those individuals having less than 12 years of education include 71% of the cases as compared with 71% for the 1967-68 fiscal year. There has been an increase in high school graduates admitted; i.e., 23% as compared to 15% last year. There have been relatively the same number of cases with some college education, 6% as compared to 7% for the 1967-68 fiscal year.

Heroin was the drug of choice for 90% of both court-committed and voluntary admissions. The remaining 10% were using amphetamines, barbiturates, or the hallucinogenic drugs either exclusively or in combination with each other.

IV. Massachusetts Correctional Institution at Framingham

Since the opening of this facility in May 1969, twenty-three individuals have been committed to the Massachusetts Correctional Institution at Framingham. Eleven of the individuals were committed under Chapter 111A, Section 6 (observation), eleven were committed under the same Chapter, Section 8 (probation) and one was committed under Chapter 123, Section 62.

The geographical distribution indicates that one-fourth of the patients resided in the Boston area while almost one-half resided in Cambridge, Somerville, Lawrence, Haverhill and Newburyport areas. Only two cases each resided in the southeastern, central and western areas of the state.

The age distribution among the patients admitted to the Massachusetts Correctional Institution at Framingham is similar to that of the other treatment units with two-thirds of the individuals under 25 years of age. The mean age was 22 and the median age was 21. The greatest proportion of the individuals are white females with less than 12 years of education.

The most predominant drug of choice was heroin which was used either exclusively or in combination with other drugs. A small number of the patients used barbiturates, amphetamines and hallucinogenic drugs.

In summary, it can be said that at the Boston State Hospital, while the drug of choice was heroin in 60% of the cases, there is a total of 32% of the patients using amphetamines and the hallucinogenic drugs. This is associated with the fact that those who use the hallucinogenic drugs are for the most part school dropouts, or individuals of high school or college age who are experimenting with these drugs.

The typical patient who is seen at the Whittier Street out-patient clinic is two years older, at 24, than the average individual seen at the Boston State clinic. Thirty-one percent of the individuals were over 30 as contrasted to 17% at Boston State. There was also a 100% increase in the number of non-whites coming to this unit, and heroin is the drug of choice in 90% of all cases. These three factors attest to the fact that this unit is reaching the hard-core members of the drug-taking subculture. The accessibility of the unit and the services offered, therefore, have attracted a considerable number of individuals who had not previously sought counseling for their drug problem.

At the East Boston clinic the characteristics of the population are somewhat different. Located in a working-class community, this clinic served fewer patients who have had any college training. Seventy-five percent of the patients reside in Boston and the white/non-white ratio is 83-15, which is consistent with the ratio in the general population of Boston.

At the Massachusetts Correctional Institution at Bridgewater heroin was the drug used by 90% of the patients. The average age is somewhat older for the voluntary patient, 26 as opposed to 22 for the court-committed individual. Another salient feature of the Bridgewater population is that there has been an increase in white individuals at this unit. For the court-committed patients there was a 4% increase in white patients, and for the voluntary patients there has been a 9% increase during the last year.

Due to the relatively small number of individuals treated at the Massachusetts Correctional Institution at Framingham, it was difficult to draw a profile of the average patient. However, even with the small number, there seems to be a trend to follow a pattern consistent with the other treatment centers. The majority of cases are white with less than 12 years of education. The average age is 22 and the drug used most predominantly was heroin.

During the past fiscal year, the Board has continued the further implementation of the three major services for which it has the responsibility of providing the Commonwealth.

I. The first service is primarily of an administrative nature, and involves providing strong central leadership to the highly interdependent treatment services that exist in the state for drug addicts. This has been accomplished by establishing goals, dramatizing issues, setting example, encouraging new ideas and projects, and instituting guidelines and standards.

Since 1965, the Board has urged the development of "Community Coalitions" whereby every institution in a community, including public and voluntary agencies, churches, educators, law enforcement, citizens, families and ex-addicts adopt a uniform policy of commitment to treat and rehabilitate drug addicts.

II. The second major service has been to structure a state-wide system of medically-oriented facilities across the Commonwealth for persons who are drug dependent, but sufficiently motivated to seek treatment on a voluntary basis. These facilities would ideally be located in community-based hospitals, and would largely attract young adults or adolescents from a middle-class background. This type of patient usually prefers to be treated at a general or non-profit institution rather than a tax-supported program, and his effort to be independent and self-supporting has been encouraged.

Attitudinal, legal and financial barriers to the full utilization of the existing hospital-medical complex in the state have already been under engagement and are slowly changing.

III. The third major service has been the gradual development of a compulsory or civil commitment program for persons with a problem of drug dependence who are before the court on a criminal offense. Because of poor motivation, voluntary efforts to treat these individuals have been inadequate, and the patients must be helped by the application of external non-punitive controls in order to insure their capacity to function.

Implementation of the civil commitment program has been of an interdisciplinary nature and involves the services of an after-care program, community mental health facilities, out-patient clinics, halfway houses, day care centers, sheltered workshops, etc. These aforementioned facilities are equally effective in the treatment of patients on a voluntary basis.

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